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Implementation of the international and regional human rights framework for the elimination of female genital mutilation

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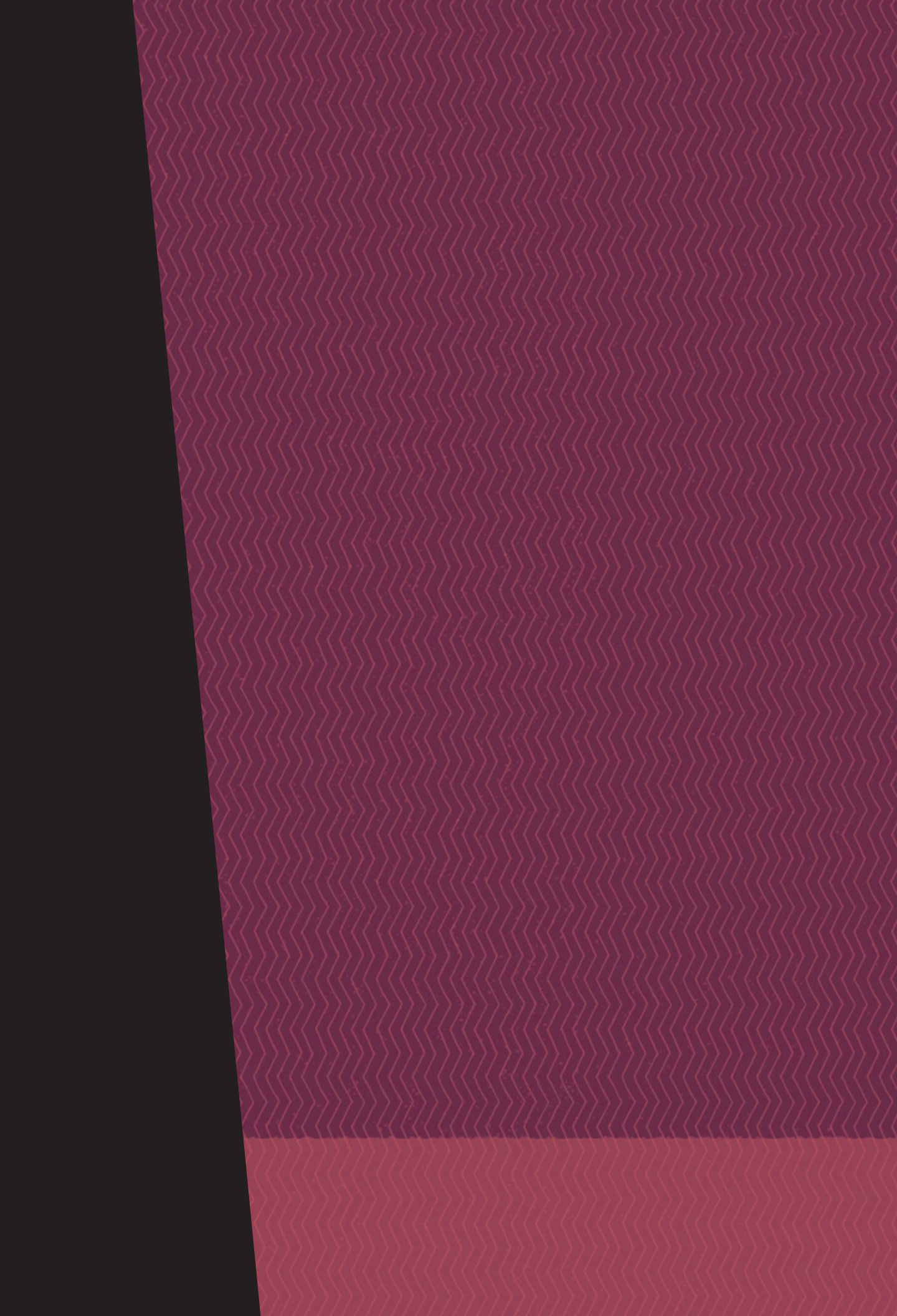
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*Implementation of the
International and Regional
Human Rights Framework
for the Elimination of
Female Genital Mutilation*





History tells us, and recent experience has shown, that laws alone cannot change social behaviour. The international community has adopted a more comprehensive and holistic strategy that incorporates human rights.

A human rights-based approach to FGM places the practice within a broader social justice agenda — one that emphasizes the responsibilities of governments to ensure realization of the full spectrum of women's and girls' human rights.



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CAT	Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
CED	Committee on Enforced Disappearances
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CERD	Committee on the Elimination of Racial Discrimination
CESCR	Committee on Economic, Social and Cultural Rights
CNLPE	National Committee to Fight the Practice of Excision (Burkina Faso)
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
DHS	Demographic and Health Survey
FGM	Female genital mutilation
FGM/C	Female genital mutilation/cutting
FIGO	International Federation of Gynecology and Obstetrics
HIV	Human immunodeficiency virus
HIV/AIDS	Human immunodeficiency virus / acquired immunodeficiency syndrome
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICN	International Council of Nurses
ICPD	International Conference on Population and Development
IOM	International Organization for Migration
MICS	Multiple Indicator Cluster Survey
MWIA	The Medical Women's International Association
NGOs	Non-governmental organizations
OHCHR	Office of the High Commissioner for Human Rights
UDHR	Universal Declaration of Human Rights
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNECA	United Nations Economic Commission for Africa
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
UPR	Universal Periodic Review
WHO	World Health Organization

CHAPTER ONE

Introduction

BACKGROUND ON THE CAMPAIGN AGAINST FGM

AIM OF THIS PUBLICATION

SCOPE AND METHODOLOGY

TERMINOLOGY



Female Genital Mutilation (FGM) is the practice of partially or totally removing the external female genitalia or otherwise injuring the female genital organs for non-medical reasons. It is often believed to be a requirement for marriage and necessary to control women's sexuality. FGM is a reproductive health and human rights concern that has devastating short-term and long-term impacts on the lives of women and girls. The procedure is risky and life-threatening for the girl both during the procedure and throughout the course of her life. FGM is considered a harmful practice and a form of violence against women.

1.1 Background on the campaign against FGM

1.1.1 FGM as a form of violence against women

Before the 1990s, the international community did not view violence against women in general and more specifically FGM as a major issue. If violence against women was recognized as an issue at all, it was seen as under the purview of national governments, not a subject of international law. Violence against women was widely viewed as a private act or a domestic matter carried out by private individuals. For this reason FGM was initially placed beyond the scope of international human rights law.

This changed in the 1990s with the global movement against violence against women. Landmark events were the adoption of General Recommendation No. 14 on female circumcision¹ (1990) and General Recommendation No. 19² on violence against women (1992) by the Committee on the Elimination of Discrimination against Women. The Committee explicitly included violence against women as a matter falling under the scope of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and thus under international human rights law.

The World Conference on Human Rights (1993) was another landmark event. The concluding document, the Vienna Declaration and Programme of Action, expanded the international human rights agenda to include gender-based violence. It advocated the importance of "working towards the elimination of violence against women in public and private life, [...] and the eradication of any conflicts which may arise between the rights of women and the harmful effects of certain traditional or customary practices [...]."³ A few months after the conference, the General Assembly adopted the Declaration on the Elimination of Violence against Women.³ This was another key step, as it recognized FGM as a form of violence against women for the first time. In article 2, the declaration expressly stated that "Violence against women shall be understood to encompass,

but not be limited to, the following: [...] female genital mutilation and other traditional practices harmful to women.” Although not legally binding, this declaration strengthened the growing international consensus that gender-based violence is a human rights violation.

1.1.2 International Conference on Population and Development

The international community addressed the human rights implications of FGM again at the International Conference on Population and Development (ICPD) in Cairo (1994). In adopting its Programme of Action, 179 States agreed to take measures to abandon FGM.⁵ The Programme of Action recognized that “In a number of countries, harmful practices meant to control women’s sexuality have led to great suffering. Among them is the practice of female genital mutilation, which is a violation of basic rights and a major lifelong risk to women’s health.”⁶

States were urged to prohibit FGM and to adopt and enforce measures to eliminate it.³ These were to include strong community outreach programmes involving village and religious leaders; education and counselling about its impact on girls’ and women’s health; and appropriate treatment and rehabilitation for girls and women who have suffered FGM. Services should also include counselling for women and men to discourage the practice of FGM.⁸ States were urged to give vigorous support to efforts by non-governmental organizations (NGOs), community organizations and religious institutions to eliminate FGM.⁹ Active discouragement of the practice was to be an integral component of primary health care, including reproductive health care programmes.¹⁰ The international community again addressed the human rights implications of FGM at the Fourth World Conference on Women in Beijing in 1995.

The international community addressed the human rights implications of FGM again at the **International Conference on Population and Development (ICPD)** in Cairo (1994).

1.1.3 From health to human rights

In the early years of the campaign against FGM, it was framed as a health issue, and efforts to eliminate it focused on the adverse health consequences of the practice.¹¹ This focus may have unintentionally promoted the ‘medicalization’ of the practice, with the result that it is increasingly being performed by medical professionals (whether in public or private clinics, homes or elsewhere) rather than by traditional practitioners.¹² However, from a human rights perspective, medicalization of the practice does not in any way make FGM more acceptable. The international community has since recognized that FGM is not only a health issue but also a matter of human rights. The international campaign to eliminate the practice has subsequently embraced the human rights framework,¹³ acknowledging that, while parents do not intend to hurt their children, FGM violates a number of recognized human rights.

Given its harmful impacts, the act itself is a basic violation of the right to achieve the maximum attainable standard of health, including the right

to sexual and reproductive health. FGM increases the risk of maternal mortality and morbidity and of contracting sexually transmitted infections, including HIV. It also violates girls' and women's rights to physical integrity.

FGM reflects inequality between the sexes and constitutes a form of discrimination against women and girls. It is nearly always carried out on minors and is therefore a violation of the rights of children. The practice also violates a person's right to be free from torture and cruel, inhuman or degrading treatment and in some cases to the right to life.

The classification of FGM as an international human rights violation has been reinforced by various United Nations agencies, for example in the 1997 joint statement against FGM by the World Health Organization (WHO), United Nations Population Fund (UNFPA) and United Nations Children's Fund (UNICEF)¹⁴ and in 'Eliminating female genital mutilation: an interagency statement' in 2008.¹⁵ These statements expressed the common commitment of United Nations entities to continue working towards elimination of FGM within a generation. This commitment is exemplified by the UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting: Accelerating change, initiated in 2008. It supports 17 countries to accelerate the abandonment of FGM.

1.2 Aim of this publication

The majority of countries worldwide have committed themselves to protecting the rights of women and girls by ratifying a number of international and regional treaties. States must comply with these standards and principles by fulfilling their obligations to take legislative, policy and other actions. In countries where FGM is practiced, laws against it have been enacted, demonstrating that in many countries it is no longer viewed as an acceptable practice but instead as a harmful violation of the rights of women and girls. At the same time, even where laws prohibiting FGM are in place, they are "not effectively implemented in many places because of the strength of traditional attitudes, and in some cases because of the existence of religious or customary legal systems" that actually support these attitudes, according to the *World Report on Violence against Children*.¹⁶ In recent years, one of the most highly debated issues is the role that laws should play in addressing a social practice that is strongly anchored in cultural beliefs and norms.¹⁷

History tells us and recent experience has shown that laws alone cannot change social behavior. The United Nations and the African Union has adopted a more comprehensive and holistic strategy that incorporates human rights. A human rights approach to FGM places the practice within a broader social justice agenda — one that emphasizes the responsibilities of governments to ensure realization of the full spectrum of women's and girls' rights.¹⁸ In order to place FGM within a human rights framework, it

A more
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is critical to know more about human rights law. The aim of this paper is to contribute to the dearth of literature focusing on the gross violation of human rights through the practice of FGM. It also addresses the corresponding duties of governments under international human rights law.

1.3 Scope and methodology

The work resulting in this publication began with an exploration of the human rights treaties and other human rights instruments/documents of the United Nations and African Union that are most generally understood to be relevant to FGM, in order to construct a human rights framework applicable to it. This research focused on specific keywords (like 'customary practice', 'harmful practice', 'cultural practice', 'traditional practice', 'female genital mutilation', 'female genital cutting', 'female circumcision'), used interchangeably. In addition databases belonging to the United Nations and regional bodies were browsed so that all relevant documents would be included in the analysis. The treaties and human rights instruments/documents were analyzed one at a time, and the information was gathered in tabular form in Excel spreadsheets. The main focus of analysis was the violation of human rights and the duties of States regarding FGM under international human rights law.

Special attention was paid to language in order to clearly distinguish between legally binding obligations of States and non-binding recommendations, and to determine their content. Five countries were selected for in-depth analysis: Burkina Faso, Egypt, Ethiopia, Kenya and Senegal. The first prerequisite for selection was implementation of the UNFPA-UNICEF Joint Programme on FGM/C: Accelerating Change (referred to hereafter as the Joint Programme) for a sufficient period of time to have yielded some results.¹⁹ Other criteria were geographic distribution (East, West and North Africa), FGM prevalence rates and availability of data and previous research.

A questionnaire was developed to obtain information on country implementation of the international human rights framework through the national legal framework (constitutional guarantee, criminal laws, etc.) and through policy measures (national action plans, support for girls, awareness-raising campaigns, training for professionals, cooperation with NGOs, etc.). The questionnaires were completed by the governments of the five countries, with UNFPA support. The responses were combined with findings culled from literature and reports of treaty monitoring bodies on implementation of the international and regional human rights framework.

This paper focuses on the work of the United Nations and the African Union. Treaties and human rights instruments adopted by other organizations (such as the Council of Europe, European Union and Organization of American States) are not included in the analysis. Issues relating to refugees and granting of asylum based on FGM are also excluded from the discussion.²⁰

1.4 Terminology

This paper uses a broad definition of the human rights framework, to include not only legally binding human rights treaties but also non-binding international documents, also referred to as 'soft law instruments'. Examples of soft-law instruments are declarations, general comments and recommendations adopted by human rights treaty bodies and General Assembly resolutions. Despite the non-binding nature of these instruments, they are highly relevant and were influential in the development of international and regional human rights law. Therefore, they are viewed as part of the human rights framework.

Since 2007 UNFPA has been using the hybrid terminology of Female Genital Mutilation/Cutting (FGM/C). However, UNFPA has now revisited its position and formally adopted the term 'Female Genital Mutilation' (FGM) in any reference to the practice from now on. Main considerations include the following:

- More than ever, we are at a time when the practice must be viewed from a human rights perspective and the term 'mutilation' better describes the practice from this viewpoint both in terms of the process and the outcome. It is UNFPA's strong belief that advocacy initiatives on the practice need to be shaped and guided in this line of thinking and its strategic plan (2014-2017) unequivocally argues for a response that is grounded in a human rights-based approach.
- The use of the term 'Female Genital Mutilation' in a number of United Nations and intergovernmental documents in reference to the practice further supports the move taken by UNFPA. One recent and very important document to mention is the first United Nations General Assembly Resolution (UNGA Resolution 67/146) on "Intensifying global efforts for the elimination of female genital mutilations"²¹. Other documents in which the term 'female genital mutilation' is used include: Report of the Secretary-General on Ending Female Genital Mutilation²², Communication from the Commission to the European Parliament and the Council: Towards the elimination of female genital mutilation, 2013²³, Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa²⁴; Beijing Declaration and Platform for Action²⁵; Eliminating Female genital mutilation: An interagency statement: OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO²⁶; and other documents. The naming of the movement of "International Day of Zero Tolerance for Female Genital Mutilation" could also be another reference on the issue.
- In the current context, in which a greater number of countries have outlawed the practice (hence categorizing it as a criminal act) and an increasing number of communities declaring abandonment of

The first United Nations General Assembly Resolution (UNGA Resolution 67/146) on "Intensifying global efforts for the **elimination** of female genital mutilations"



the practice (recognizing its harmfulness), it follows that the initial social and cultural perceptions of the community about the practice has already been challenged by communities themselves along with national, regional, and international stakeholders working on the issue. Hence, now is the time to reinforce and accelerate the momentum towards the full abandonment of the practice by emphasizing the human rights based approach and perspective.

1.5 Outline

Chapter 2 gives general information about the practice of FGM. Chapter 3 provides an overview of the international human rights framework. Chapter 4 places FGM in the human rights framework, focusing specifically on the human rights violated by the practice. It includes an overview of the binding international and regional treaties in which these human rights are enshrined, such as the Convention on the Elimination of All Forms of Discrimination against Women, the Convention on the Rights of the Child and the African Charter on Human and People's Rights. Chapter 4 also covers non-binding instruments, such as those resulting from United Nations conferences and summits, which reaffirm human rights and call on governments to strive for their full respect, protection and fulfilment. Chapter 5 presents and analyzes the duties of states that follow from the human rights framework with regard to FGM. Chapter 6 examines human rights monitoring mechanisms and chapter 7 look at the implementation of the human rights framework in five countries. Finally, the last section presents the conclusions and recommendations for further actions for UNFPA and its partners in their continuing efforts to accelerate the universal elimination of FGM.

CHAPTER TWO

Facts on Female Genital Mutilation

DEFINITION OF FGM

PREVALENCE OF FGM

WHY THE PRACTICE CONTINUES

HEALTH CONSEQUENCES OF FGM



2.1 Definition of FGM

FGM is defined by the WHO as a procedure that involves the “partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons”.²⁷ There are four broad types of FGM. The most severe form is infibulation, which involves excision of part or all of the external genitalia and the stitching/narrowing of the vaginal opening.²⁸ FGM is performed on girls and women at varying ages. The procedure is mostly carried out on girls between infancy and age 15, and occasionally on adult women, depending on the community or ethnic group. The practice is often performed by traditional practitioners, without anesthesia, using scissors, razor blades or broken glass. More recently, in some countries it is also performed by trained health personnel, including physicians, nurses and midwives; this is referred to as ‘medicalization’ of the practice.

2.2 Prevalence of FGM

Despite the global and national efforts to promote abandonment of the practice, FGM still remains widespread in different parts of the world. Over 140 million girls and women have undergone female genital mutilation. The practice is most common in 29 countries in Africa; in some countries in Asia, the Middle East²⁹ and Latin America;³⁰ and among migrants from these areas. Prevalence of FGM varies across countries as it is a practice strongly influenced by sociocultural contexts in each of the countries. Prevalence among girls aged 15 to 19 ranges from 96.7 per cent (Somalia) to 0.4 per cent (Cameroon), indicating a wide regional variation, with all the implications that has in terms of advocacy and programming to end the practice (Figure 1).

When considering prevalence of FGM in any given country, it is important to go a step further and analyze the prevalence at subnational level, as aggregate national data usually mask substantial subnational disparities. For instance, a recent study in Kenya by UNFPA, UNICEF and the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women) found that FGM tends to be more prevalent among indigenous communities. Average trends from 1998, 2003 and 2008/2009 show a decline in the percentage of adolescents and women aged 15-49 years who have undergone FGM: 38 per cent in 1998, 32 per cent in 2003 and 27 per cent by 2008. Yet the practice remains far more prevalent among the Somali (98 per cent), the Kisii (96 per cent) and the Maasai (73 per cent). An analysis carried out for Guinea also reveals important disparity in the prevalence and trend of FGM among different religious and ethnic groups. Prevalence in the Muslim community is

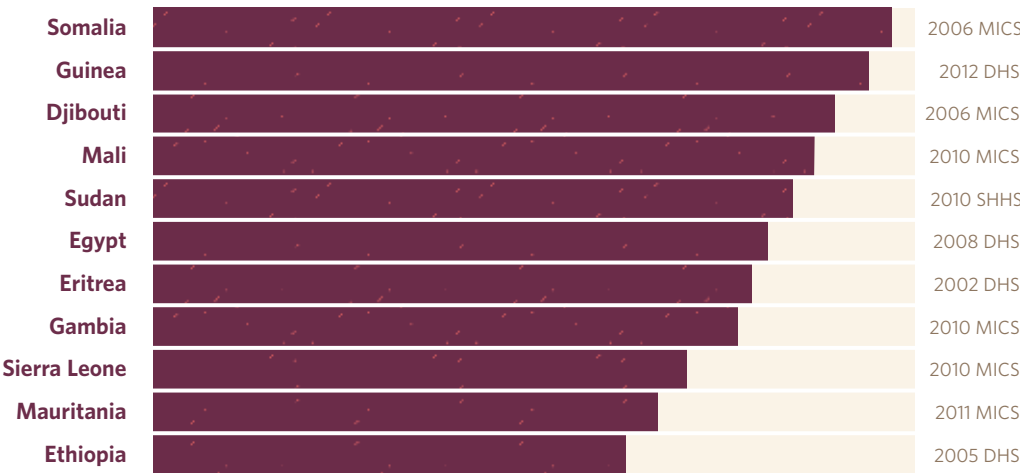
Percentage of girls aged 15-19 who have experienced any form of FGM
By country, most recent data, 1997-2012

FIGURE 1

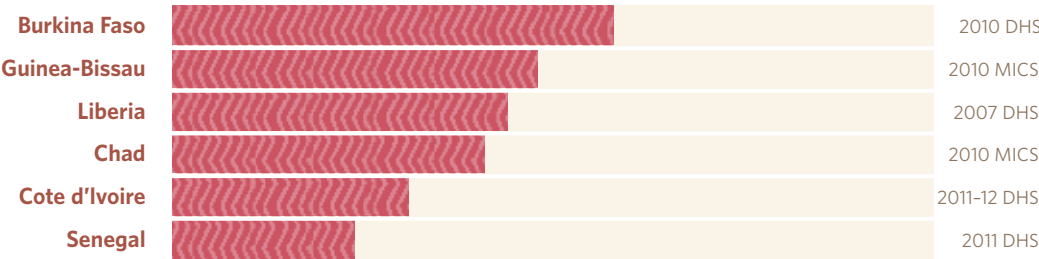
FGM CONCENTRATED PERCENTAGE OF GIRLS AGED 15-19
COUNTRIES WHO HAVE EXPERIENCED ANY FORM OF FGM

DATA SOURCE

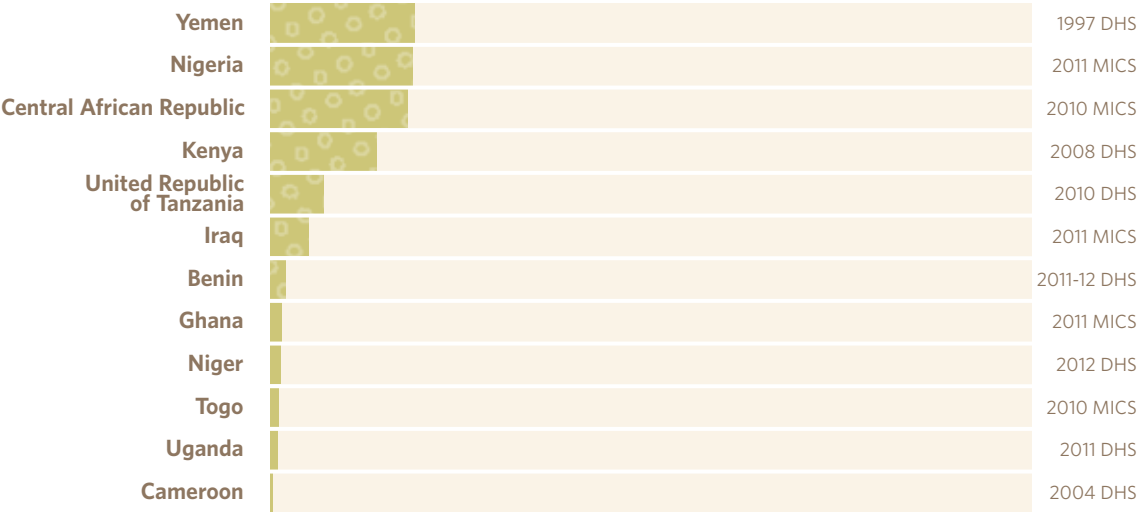
High Prevalance Countries (more than 60%)



Middle prevalence countries (20-60%)



Low prevalence countries (less than 20%)



Source: UNFPA, 'Demographic Perspectives on Female Genital Mutilation', 2014.

notably higher than in the Christian community, and it is significantly lower for communities from the Guerze ethnic group compared to the other ethnic groups in the country.³¹

Reduction in FGM prevalence is observed in most of the countries but at different levels and generally at a rate that is by far below what the situation actually demands. If the current trend continues, UNFPA projects that 86 million girls born from 2010-2015 are at risk of being cut by 2030. Hence, there is a need to accelerate efforts to have meaningful impact in the lives of girls and women who are at risk of the practice. This is why various initiatives, including the largest global initiative, the UNFPA-UNICEF Joint Programme, are under way to protect girls and women from the practice of FGM.

2.3 Why the practice continues

A range of factors contribute to the continued practice of FGM. Populations that practice FGM variously refer to it as a religious requirement, an aid to female hygiene and a tool to control or reduce female sexuality. In many places, the practice is often linked to a ritual marking the coming of age and initiation to womanhood. FGM functions as a self-enforcing social convention and acts as a social norm upheld by individuals and families in a community because they believe that their group or society will impose social sanctions if they do not maintain the practice.³² In communities where the practice is viewed as a prerequisite for marriage and where women are largely dependent on men, economic necessity can be a determinant. FGM also provides a source of income to community practitioners who perform the practice. The unwillingness of women themselves to give up the practice is based on their view of it as a long-standing tradition passed from generation to generation.

2.4 Health consequences of FGM

FGM has no health benefits, and it harms the health and lives of girls and women in many ways. It involves removing and damaging healthy and normal female genital tissue and interferes with the natural functions of girls' and women's bodies. Its immediate and long-term health consequences depend on the type performed, the experience of the practitioner, the hygienic conditions under which it is performed and the amount of resistance and the health status of the individual undergoing the procedure.



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Complications may occur in all types of FGM but are most frequent with infibulation. In the short term, it may cause hemorrhage, excessive pain, shock, tetanus or sepsis (bacterial infection), abscesses, tissue injury, pelvic fracture, urine retention, open sores and injury to genital tissue. Death can be caused by hemorrhage or infection, including tetanus and shock. Long-term health consequences include recurrent bladder and urinary tract infections (which can lead to kidney damage), cysts and abscesses, and harmful maternal and neonatal outcomes, including infertility, increased risk of childbirth complications and need for later surgeries.³³ Women who have undergone the practice face a significantly greater risk of needing Caesarean section and face more post-partum difficulties compared to women who have not been cut. Death rates among babies during and immediately after birth are higher for those born to mothers who have been cut. FGM can also cause psychological harm. Documented effects include post-traumatic stress disorder, anxiety, depression and psychosexual problems.³⁴

CHAPTER THREE

International and Regional Human Rights Framework

WHAT ARE HUMAN RIGHTS?

INTERNATIONAL BILL OF RIGHTS

UNITED NATIONS CONVENTIONS

TREATY MONITORING BODIES

HUMAN RIGHTS COUNCIL

AFRICAN UNION HUMAN RIGHTS FRAMEWORK



Human rights
are categorized
as civil, political,
economic, social
and cultural rights;
all are universal,
inalienable,
interrelated,
interdependent
and indivisible.

3.1 What are human rights?

Human rights are commonly understood as inalienable fundamental legal guarantees to which a person is inherently entitled simply because she or he is a human being.³⁵ Human rights are categorized as civil, political, economic, social and cultural rights; all are universal, inalienable, inter-related, interdependent and indivisible. Human rights, which entail both rights and obligations, are reflected in numerous treaties that are binding under international law. They are also reflected in non-binding documents, such as resolutions, recommendations, guidelines, declarations and principles. Understanding this framework is important to promoting, protecting and realizing human rights. This chapter provides an overview of the international human rights framework. It serves as a useful backdrop in understanding the human rights that are violated by the practice of FGM.

3.2 International Bill of Rights

The protection of human rights became an issue of concern to the international community in the 20th century. The Second World War led to a climate of readiness for advances in recognizing and respecting human rights. The Universal Declaration of Human Rights (UDHR), adopted by the United Nations General Assembly on 10 December 1948,³⁶ represented the first global expression of rights to which all human beings are inherently entitled. As its name suggests, the UDHR is not a legally binding treaty, but it has come to be regarded as the accepted world standard on human rights. Immediately after its adoption, the process of drafting a legally binding instrument enshrining the rights of the UDHR began. In December 1966, the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR) were adopted.³⁷ Together, the UDHR, ICCPR and ICESCR are commonly referred to as the International Bill of Rights. These are the earliest and most authoritative human rights instruments. Both covenants are widely ratified; the ICCPR has 167 State parties and the ICESCR 160 State parties.

3.3 United Nations conventions

In addition to these two covenants, the United Nations has adopted a number of legally binding international human rights treaties. Some of them are supplemented by optional protocols dealing with specific concerns. Together with the UDHR and the two covenants, these treaties form the core of the legal framework for the protection of human rights globally.³⁸

The following human rights treaties set the standard for the protection and promotion of human rights:

- International Convention on the Elimination of All Forms of Racial Discrimination ³⁹
- Convention on the Elimination of All Forms of Discrimination against Women ⁴⁰
- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) ⁴¹
- Convention on the Rights of the Child (CRC) ⁴²
- International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families ⁴³
- Convention for the Protection of All Persons from Enforced Disappearance ⁴⁴
- Convention on the Rights of Persons with Disabilities (CRPD). ⁴⁵

These human rights treaties are legally binding upon Member States. When a State accepts a treaty through ratification, accession or succession, it assumes obligations and duties under international law to respect, protect and fulfil the rights set out in the treaty. The obligation to respect means that States must refrain from interfering with or limiting the enjoyment of human rights. The obligation to protect requires States to interfere with attempts by third parties to violate the rights of others and to provide remedies when rights are violated. The obligation to fulfil means that States must take positive action to progressively achieve the enjoyment of human rights.

3.4 Treaty monitoring bodies

Treaty monitoring bodies are committees of independent experts that monitor implementation of the substantive provisions of the core international human rights treaties.⁴⁶ All treaty bodies except the Subcommittee on Prevention of Torture are mandated to receive and consider reports. Each State party is obligated to submit regular reports to the relevant treaty body on how the rights are being implemented. The treaty body examines the report and publishes its concerns and recommendations, referred to as 'concluding observations'. The reporting system is an important tool through which the international community assesses what it has achieved and what more it needs to do to promote and protect human rights.

There are currently 10 human rights treaty bodies:

- Committee on the Elimination of Racial Discrimination (CERD)
- Human Rights Committee
- Committee on Economic, Social and Cultural Rights (CESCR)
- Committee on the Elimination of Discrimination against Women
- Committee against Torture
 - Subcommittee on Prevention of Torture
- Committee on the Rights of the Child
- Committee on Migrant Workers
- Committee on Enforced Disappearances (CED)
- Committee on the Rights of Persons with Disabilities.

Eight of the treaty bodies listed above⁴⁷ may consider individual complaints from individuals alleging that a State party to that treaty has violated their rights. Individual complaints can be brought only against a state that has recognized the competence of the committee established under the relevant treaty or when the state became a party to the relevant Optional Protocols. Some treaty bodies⁴⁷ may initiate country inquiries if they receive reliable information containing well-founded indications of serious, grave or systematic violations of the conventions by a State party. In addition, some of the treaty bodies may also consider inter-state complaints.⁴⁹ Each of the treaty bodies publishes its interpretation of the content of the treaty provisions in the form of 'general comments' or 'general recommendations'.⁵⁰ These cover a wide range of subjects, from the comprehensive interpretation of substantive provisions, to general guidance on the information that should be submitted in State reports relating to specific articles of the treaties. General comments have also dealt with wider, cross-cutting issues, such as the role of national human rights institutions, rights of persons with disabilities, violence against women and rights of minorities.⁵¹ This interpretive task of the treaty bodies is crucial in developing standards that States must meet, and it contributes to the dynamic nature of treaties.

3.5 Human Rights Council

The Human Rights Council is an inter-governmental body within the United Nations system that is responsible for strengthening the promotion and protection of human rights and for addressing human rights violations and making recommendations on them. It has a complaint procedure that allows individuals and organizations to bring human rights violations to the council's attention.^{52, 53}

3.5.1 Universal Periodic Review

The Universal Periodic Review (UPR) provides for review of the human rights situations of all UN Member States. Created through United

Nations General Assembly resolution 60/251 on 15 March 2006, it is a State-driven process, under the auspices of the Human Rights Council. It provides the opportunity for each country to declare what actions it has taken to improve fulfilment of human rights in its country and to fulfil its human rights obligations.⁵⁴ It also allows States to make recommendations to other States on fulfilment of these obligations.

3.5.2 Special procedures

The special procedures of the Human Rights Council are independent human rights experts with mandates to monitor, examine, advise and publicly report on human rights situations in specific countries or territories, known as country mandates,⁵⁵ or on major phenomena of human rights violations worldwide, known as thematic mandates.⁵⁶ Special procedures are either an individual (called a 'special rapporteur' or 'independent expert') or a working group.

3.6 African Union human rights framework

Regional human rights laws supplement and complement the international human rights framework, by protecting and promoting human rights in specific areas of the world. On the African continent, the principal human rights instrument that promotes and protects human rights and basic freedoms is the African Charter on Human and Peoples' Rights of 1981, also known as the Banjul Charter. The charter, which came into effect on 21 October 1986, deals with individual human rights and the collective rights of peoples. It sets forth civil and political rights (such as the right to life, freedom of religion, freedom of torture), as well as a limited number of economic and social rights (such as the right to work, to health and to education). The African Commission on Human and Peoples' Rights is responsible for promoting and protecting human rights and collective rights in Africa, as well as for interpreting the charter and considering individual complaints of violations of it. The commission was set up in 1987 and is now headquartered in Banjul (The Gambia). A protocol to the charter, adopted in 1998, called for creation of the African Court on Human and Peoples' Rights. Another protocol to the charter pledges comprehensive rights to women. Called the Maputo Protocol, it was adopted by the African Union on 11 July 2003.

The African Charter on the Rights and Welfare of the Child (ACRWC) was adopted by the Organization of African Unity (predecessor of the African Union) in 1990. Like the CRC, the ACRWC is a comprehensive instrument that sets out rights and defines universal principles and norms for children. The African Committee of Experts on the Rights and Welfare of the Child, whose mission is to promote and protect the rights established by the ACRWC, was formed in July 2001. Another important document is the Africa Youth Charter, adopted by African Union countries in Gambia in 2006. This document contains references to freedom from harmful practices as a human right.⁵⁷

The Universal Periodic Review (UPR)
provides for review of the human rights situations of all UN Member States.

CHAPTER FOUR

International Human Rights Violated by FGM

THE RIGHT TO BE FREE FROM GENDER DISCRIMINATION

THE RIGHT TO LIFE

THE RIGHT TO PHYSICAL AND MENTAL INTEGRITY,
INCLUDING FREEDOM FROM VIOLENCE

THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH

THE RIGHT NOT TO BE SUBJECTED TO TORTURE OR
INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT

THE RIGHTS OF THE CHILD

THE RIGHTS OF PERSONS WITH DISABILITIES

OTHER INTERNATIONAL HUMAN RIGHTS



This chapter lays out the international human rights framework relating to FGM in the context of the United Nations and the African Union. It analyses the human rights of girls and women that are violated by the practice of FGM and notes the treaties and other international and regional instruments and documents in which they are enshrined.

4.1 The right to be free from gender discrimination

Discrimination against women, as defined in article 1 of CEDAW, is "... any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field." The practice of FGM fits within the definition and can be seen as a form of gender discrimination. The practice itself reflects deep-rooted inequality between the sexes. FGM is a practice reserved for women and girls that has the effect of nullifying their enjoyment of fundamental rights. Because it is aimed at controlling women's sexuality, it incorporates a fundamental discriminatory belief in the subordinate role of women and girls in society.

The prohibition of gender discrimination is supported in numerous international and regional human rights instruments. It is a fundamental principle of human rights law. Article 2 of the UDHR reads as follows: "Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, color, sex [...]" The right to be free from discrimination is also included in the ICCPR (arts. 2, 3 and 26), the ICESCR (arts. 2 and 3), CEDAW (arts. 1, 2 and 5), the CRC (art. 2) and the Banjul Charter (arts. 18 and 28).

4.2 The right to life

In the most extreme cases, when the procedure results in death, FGM violates the right to life. It may also contribute to maternal and neonatal death. The right to life is considered a core human right and is protected by a number of international instruments, including article 3 of the UDHR, "Everyone has the right to life, liberty and security of person", and article 6 of the ICCPR, "Every human being has the inherent right to life." Furthermore, this right is pledged by article 6 of the CRC, "States Parties recognize that every child has the inherent right to life" and article 4 of the Banjul Charter, "Every human being shall be entitled to respect for his life."

4.3 The right to physical and mental integrity, including freedom from violence

FGM violates numerous human rights associated with physical integrity, including the inherent dignity of the person, the right to liberty and security of the person, and the right to privacy. FGM contravenes the right

to physical integrity because the practice is premised on the notion that women's bodies are inherently imperfect and require correction. FGM harms or destroys all women's outer sexual organs and may cause psychological damage. The partial or complete loss of sexual function constitutes a violation of a woman's right to physical integrity and mental health. This is an act of violence that threatens women's safety and disrespects women's inherent dignity. The pain inflicted by FGM often does not end with the initial procedure but continues throughout a woman's life. The physical and psychological trauma affects the full emotional development of girls and women. Respect for women's dignity implies acceptance of their physical qualities, including the natural appearance of their genitals and their normal sexual function. A decision to alter those qualities should not be imposed upon a woman or a girl for the purpose of reinforcing social norms.⁵⁸

FGM also violates the right to liberty and security of the person encompassed in the right to physical integrity. This includes the right to make independent decisions in matters affecting one's own body. Girls are deprived of these rights when they are subjected to FGM either against their will or before they have reached an age at which they can give meaningful consent. Deprivations of liberty and security are most obvious when girls are forcibly restrained during the procedure.⁵⁹ However, subjecting non-protesting girls and women to FGM without their full, informed consent equally violates their right to physical integrity. FGM violates privacy rights, because it is an intervention into one of the most intimate aspects of a woman's life. FGM also seriously restricts a woman's personal freedom, since it precludes her from determining her own sexual and emotional life or personal development.

As stated above, the United Nations has recognized FGM as a form of violence against women. Statements issued by various bodies (the General Assembly,⁶⁰ Committee on the Elimination of Discrimination against Women,⁶¹ Special Rapporteur on violence against women⁶²) give evidence to this fact.

The right to physical integrity is considered a core human right and is protected by a number of international and regional instruments, including article 1 of the UDHR, which states that "All human beings are born free and equal in dignity and rights", and article 9 of the ICCPR: "Everyone has the right to liberty and security of person." The preambles of both the ICCPR and ICESCR state that "...recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world." In addition, article 19 of the CRC says that, "States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence." Furthermore, the Banjul Charter says in article 4 that "Every human being shall be entitled to respect for [...] the integrity of his person" and in article 5 that "Every individual shall have the right to the respect of the dignity inherent in a human being."

FGM also violates the right to make independent decisions in matters affecting one's own body.

4.4 The right to the highest attainable standard of health

FGM is a violation of the right to the enjoyment of the highest attainable standard of health, because women and girls who are subjected to it are exposed to short-term and long-term harm to their physical, psychological, sexual and reproductive health, including during childbirth. The physical and psychological health complications resulting from FGM have been extensively documented. Studies have also shown the harmful impact of the practice on maternal and neonatal outcomes. Compared with women who have not been cut, women who have undergone FGM run a significantly greater risk of requiring a Caesarean, an episiotomy; and an extended stay in hospital. They are also a greater risk of suffering post-partum hemorrhage. Death rates among babies during and immediately after birth are also higher for those born to mothers who have undergone FGM. It is estimated that an additional one to two babies per 100 deliveries die as a result of FGM.⁶³ The consequences of FGM for most women who deliver outside the hospital setting are believed to be even more severe, especially in places where health services are weak or women cannot easily access them.

The UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health said in his report that "Rape and other forms of sexual violence, including [...] female genital mutilation/cutting (FGM/C) and forced marriage all represent serious breaches of sexual and reproductive freedoms, and are fundamentally and inherently inconsistent with the right to health."⁶⁴

The right to the highest attainable standard of physical and mental health is enshrined in a number of international and regional instruments. The UDHR states in article 25 that "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family." Article 12 of the ICESCR states that, "The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." Article 24 of the CRC and article 12 of CEDAW also address the right to health. The Banjul Charter discusses it in article 16: "Every individual shall have the right to enjoy the best attainable state of physical and mental health."

4.5 The right not to be subjected to torture or inhuman or degrading treatment or punishment

The practice of FGM has been considered a form of torture and cruel, inhuman and degrading treatment. The Committee against Torture clearly stated in General Comment No. 2 that FGM falls within its mandate.⁶⁵ In addition, the UN Special Rapporteur on violence against women⁶⁶ and the UN Special Rapporteur on torture⁶⁷ have both recognized that FGM can amount to torture under CAT.

The right to be free from torture is considered to be *jus cogens*, a norm of international law that cannot be derogated from by States, whether or

not they have signed any international convention or document. The CAT, in article 1, paragraph 1, says that “the term ‘torture’ means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.”

All elements of this definition are met in the case of FGM. The first element is “severe pain or suffering.” FGM leads to physical and psychological short- and long-term health consequences. Manfred Nowak, the Special Rapporteur on torture, has argued that “the pain inflicted by FGM does not stop with the initial procedure, but often continues as ongoing torture throughout a woman’s life.”⁶⁸

The second element is the “intentional infliction [of pain] [...] for any reason based on discrimination of any kind.” FGM is intentionally inflicted, and the parents, traditional practitioners, medical staff know that they are inflicting pain and that the health consequences might be extremely serious. In addition, FGM is a form of discrimination on the basis of gender.

The third element is “the consent or acquiescence of a public official”. FGM is most often performed in private settings beyond the view of public officials. However, according to the 2008 Report of the UN Special Rapporteur on torture, FGM can amount to torture if States fail to act with due diligence to protect, prevent, investigate and, in accordance with national legislation, punish FGM. In other words, States have the responsibility to take all the necessary measures to eradicate FGM. The Special Rapporteur further noted, “It is clear that even if a law authorizes the practice, any act of FGM would amount to torture and the existence of the law by itself would constitute consent or acquiescence by the State.”⁶⁹

The first UN Special Rapporteur on torture, Mr. P. Kooijmans, clarified this fact in 1986. While discussing the notion of the qualified perpetrator, he argued that, “Nevertheless, the authorities’ passive attitude regarding customs broadly accepted in a number of countries (i.e. sexual mutilations and other tribal traditional practices) might be considered as ‘consent or acquiescence’, particularly when these practices are not prosecuted as criminal offences under domestic law, probably because the State itself is abandoning its function of protecting the citizens from any kind of torture.”⁷⁰

The right not to be subjected to torture or inhuman or degrading treatment or punishment is enshrined in a number of international and regional instruments. Article 5 of the UDHR and article 7 of the ICCPR say that “No

FGM is intentionally inflicted,
and the parents,
traditional
practitioners,
medical staff
know that they
are inflicting pain.

one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.”⁷¹ Article 37 of the CRC states that, “No child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment.” Article 39 of the CRC (requiring measures to promote the recovery and reintegration of a child victim of neglect, exploitation, abuse, torture or armed conflict) and all articles of CAT are relevant. In addition, the Banjul Charter addresses torture in article 5: “Every individual shall have the right to the respect of the dignity inherent in a human being and to the recognition of his legal status. All forms of exploitation and degradation of man particularly slavery, slave trade, torture, cruel, inhuman or degrading punishment and treatment shall be prohibited.”

4.6 The rights of the child

FGM is commonly performed upon girls in the age range of birth to 15 years. Therefore, the international community has generally regarded FGM as a violation of the rights of the child. In the concluding observations of the Committee on the Rights of the Child regarding Togo in 1997, the Committee explicitly directed governments to enact legislation that would abolish the practice of FGM as it is a violation of the rights of children.⁷²

Children generally cannot adequately protect themselves or make informed decisions about matters that may affect them for the rest of their lives.⁷³ Therefore, international human rights law grants children special protections, codified in the CRC, which is one of the most widely ratified treaties. Currently 193 countries have ratified, accepted or acceded to the CRC (some countries with stated reservations or interpretations).⁷⁴ The negative effects of FGM on children’s development breach the best interest of the child, a concept that is central to the CRC, found in article 3: “...the best interests of the child shall be a primary consideration.” The same notion can be found in article 4 of the ACRWC.

Article 24 of the CRC specifically mentions traditional practices, saying that “States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.” Article 21 of the ACRWC also addresses harmful social and cultural practices: “States Parties to the present Charter shall take all appropriate measures to eliminate harmful social and cultural practices affecting the welfare, dignity, normal growth and development of the child and in particular: (a) those customs and practices prejudicial to the health or life of the child; and (b) those customs and practices discriminatory to the child on the grounds of sex or other status.”

More generally, FGM violates children’s rights as defined in the CRC and the ACRWC, such as the right to be free from discrimination (art. 2 of the CRC and art. 3 of the ACRWC), the right to be protected from all



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forms of mental and physical violence and maltreatment (arts. 16 and 19 of the CRC and art. 10 of the ACRWC), the right to the highest attainable standard of health (art. 24 of the CRC and art. 14 of the ACRWC), freedom from torture or other cruel, inhuman or degrading treatment or punishment (art. 37 of the CRC and art. 16 of the ACRWC) and the right to life (art. 6 of the CRC and art. 5 of the ACRWC).

FGM is often performed without the consent of the girl, therefore breaching article 12 of the CRC: "States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child." Article 7 of the ACRWC also addresses the right to freedom of expression. The international human rights framework acknowledges the role of the parents and the family in making decisions for children, but places the ultimate responsibility for protecting the rights of the child in the hands of the government (see also art. 5 of the CRC).

4.7 The rights of persons with disabilities

There is evidence that FGM can result in disability and maternal morbidities. The health consequences of FGM (especially from infibulation) can be considered a disability inflicted after birth.

The CRPD established the right of persons with disabilities to habilitation and rehabilitation services (art. 26). This includes the obligation to ensure access to care to correct injuries from FGM. The State has an obligation to provide psychosocial and other rehabilitation services for persons with disabilities.

4.8 Other international human rights

When discussing the human rights violated by the cultural practice of FGM, it is important to also address the counter-arguments invoked by its supporters. The right of people to participate in their culture,⁷⁵ the rights of minorities⁷⁶ and the right to religious freedom⁷⁷ (despite the lack of a religious duty to practice FGM) are often raised to suggest that FGM should not be subject to government intervention, and that government action to prevent FGM is an intolerable intrusion.⁷⁸ Although the international human rights framework has recognized the right to culture, the rights of minorities and the right to religious freedom, these rights are not absolute, and international human rights law recognizes prescribed limitations. As prescribed by the human rights instruments, governments need to balance these rights against their duty to protect the fundamental rights of every member of society, including individual human rights, health and safety. UN treaty monitoring bodies and other human rights mechanisms have clarified that culture and religion cannot be invoked to justify the violation of the rights of women and girls.

CHAPTER FIVE

Duties of States

OBLIGATIONS OF STATES

RECOMMENDATIONS FOR STATES



To what extent do States have a duty to ensure that girls and women in their jurisdiction can enjoy their human rights? Addressing FGM as a violation of human rights places a responsibility on States. Under international and regional human rights law, they have a duty not only to refrain from violating rights but also to ensure protection and fulfillment of human rights in their jurisdictions and policies. States can be held responsible for failing to take steps to enable women and girls to enjoy and secure the human rights described in chapter 4 that protect them from FGM. A State's duty to take action against FGM has its foundations in the provisions of the international human rights treaties, but it is more elaborated upon in the so-called 'soft law' instruments. This chapter analyses the duties of States, including obligations and recommendations, which follow from the international (United Nations) and regional (African Union) human rights frameworks regarding FGM.

5.1 Obligations of States

International human rights treaties require States to respect protect and fulfil the enjoyment of individual rights in their jurisdictions. States parties have a due diligence obligation⁷⁹ to take all necessary steps to enable every person to enjoy the rights set out in chapter 4 of this publication.⁸⁰ Important to note is that States should refrain from invoking any custom, tradition or religious consideration to avoid their obligations with respect to FGM. The General Assembly Declaration on the Elimination of Violence against Women stated in article 4 that "States should condemn violence against women and should not invoke any custom, tradition or religious consideration to avoid their obligations with respect to its elimination."⁸¹ Similar wordings can be found in other General Assembly resolutions,⁸² the Beijing Declaration,⁸³ the reports of the Special Rapporteur on violence against women⁸⁴ and the agreed conclusions of the Commission on the Status of Women.⁸⁵ At the international level, traditional practices are specifically mentioned in CEDAW and the CRC. Article 5 of CEDAW requires States parties to "...take all appropriate measures: (a) To modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women." Article 24 of the CRC says in sub-paragraph 3 that "States Parties shall take all effective and appropriate measures with a view to abolishing traditional

practices prejudicial to the health of children.” At the regional level, the Maputo Protocol addresses the elimination of harmful practices, including FGM. Article 5 says that “States Parties shall prohibit and condemn all forms of harmful practices which negatively affect the human rights of women and which are contrary to recognized international standards. States Parties shall take all necessary legislative and other measures to eliminate such practices.” These measures are: (a) awareness-raising through information campaigns, formal and informal education, and outreach; (b) prohibition, through legislative measures backed by sanctions, of all forms of FGM, including medicalized procedure; (c) support for victims of FGM in the form of health care, legal counsel, psychological care and support, and education and training; and (d) protection of women who are potential victims of FGM or other forms of violence, abuse or intolerance.

While there are regional frameworks that address violence against women and girls,⁸⁶ there is no legally binding international treaty specifically dealing with violence against women and girls or more specifically FGM. Nevertheless, General Comments of CEDAW and CRC⁸⁷ can be viewed as authoritative interpretative instruments, which give rise to a normative consensus on harmful practices and the application of treaties. The recently adopted Joint CEDAW/CRC General Comment on harmful practices of November 2014 clarifies for example the obligations of States parties to CEDAW and CRC by “providing authoritative guidance on legislative, policy and other appropriate measures that must be taken to ensure full compliance with their obligations under the two Conventions to eliminate harmful practices.” Other (non-binding) human rights instruments are also important to consider, including UN General Assembly Resolutions, Declarations, Programmes and Plans of Action. These documents contain recommendations for governments to take action in the field of FGM.

General Comments of CEDAW and CRC can be viewed as authoritative interpretative instruments, which give rise to a normative consensus on harmful practices and the application of treaties.

5.2 Recommendations for States

Recommendations that follow from the international and regional human rights framework, which are not binding upon states, are classified in the following categories and discussed further below.

- National laws
- Policies
- Financial support
- Data collection
- Educational, training and awareness-raising programmes
- Training of professionals
- Support of civil society organizations
- Support services
- Involvement of all actors
- Social and economic reintegration of FGM practitioners.

5.2.1 National laws

States should ensure the enactment and effective enforcement of national laws that prohibit FGM; protect women and girls from this form of violence; and end impunity. The ICPD Programme of Action stated that "Governments are urged to prohibit female genital mutilation wherever it exists."⁸⁸ The Beijing Declaration and Platform for Action asked governments to take action and to "enact and enforce legislation against the perpetrators of practices and acts of violence against women, such as female genital mutilation."⁸⁹ In resolution 53/117 the General Assembly called upon States to "...develop and implement national legislation and policies prohibiting traditional or customary practices affecting the health of women and girls, including female genital mutilation, inter alia, through appropriate measures against those responsible, and to establish, if they have not done so, a concrete national mechanism for the implementation and monitoring of legislation, law enforcement and national policies."⁹⁰ Fundamentally, FGM should be criminalized at the national level, and perpetrators of FGM should be prosecuted.

Prosecution of FGM in Egypt

BOX 1

Egypt has gone through an important milestone in its judicial history: for the first time, an FGM case has made its way to the criminal court for prosecution. The case concerns a girl who died in 2013 as a result of an FGM procedure in a private clinic. In March 2014 the General Prosecutor's office referred both the doctor and the girl's father to the criminal court for prosecution.⁹¹

Legal obstacles to prosecution of FGM cases need to be removed and therefore laws need to be reviewed and revised, adjusted or amended as appropriate. This follows from several documents, including General Assembly resolutions,⁹² general comments of treaty bodies,⁹³ reports of special rapporteurs,⁹⁴ UN Secretary-General reports⁹⁵ and World Health Assembly resolutions.⁹⁶ In addition, several human rights documents⁹⁷ and reports of treaty monitoring bodies⁹⁸ recommend that States put in place adequate and concrete national accountability mechanisms for implementation and monitoring of legislation, law enforcement and national policies.

5.2.2 Policies

Also needed is adoption of effective and appropriate measures to prevent and abolish FGM.⁹⁹ States are called upon to develop policies, regulations, protocols and rules to ensure the effective implementation of national legislative frameworks on eliminating FGM.¹⁰⁰ Various bodies have called upon States to develop national action plans and strategies to eradicate FGM.¹⁰¹ It has been recommended, for example, that States parties include

in their national health policies appropriate strategies aimed at eradicating FGM in public health care. One such strategy could require health personnel, including traditional birth attendants, to explain the harmful effects of FGM to patients.¹⁰² States are also called upon to ensure that national action plans and strategies are comprehensive, multidisciplinary and multi-stakeholder in scope and incorporate clear targets and indicators for effective monitoring, impact assessment and coordination of programmes among all stakeholders. Coordination mechanisms should continue to be strengthened, as recommended by the General Assembly.¹⁰³ These policies are necessary to “modify the social and cultural patterns of conduct of men and women and to eliminate prejudices, customary practices and all other practices based on inequality, ideologies of inequality or gender stereotypes.”¹⁰⁴

5.2.3 Financial support

States have also been urged to allocate sufficient financial resources for implementation of policies and legislative frameworks aimed at abandoning FGM.¹⁰⁵ In his 2012 Report on Ending Female Genital Mutilation, the Secretary-General wrote that “Strong political commitment is required at the national level, demonstrated by comprehensive national laws and policies and the allocation of sufficient resources, including budgets, for their implementation.”¹⁰⁶ The General Assembly has also urged States to actively support other “targeted innovative programmes” that address ending FGM.¹⁰⁷

5.2.4 Data collection

Another recommendation for States is to collect and disseminate basic data about prevalence, trends, attitudes and behavior regarding FGM, as well as about reported cases and enforcement of legislation. This recommendation can be found in many human rights documents.¹⁰⁸ The data can be collected by universities, medical or nursing associations, national women’s organizations or other bodies.¹⁰⁹ The ICPD Programme of Action in 1994 noted that

Public inquiry on violation of women’s reproductive health rights in Kenya

BOX 2

The Kenya National Commission on Human Rights launched a public enquiry in 2011 in response to a 2009 complaint alleging systematic violations of women’s reproductive health rights in health facilities. Filed by the Federation of Women Lawyers-Kenya and the Center for Reproductive Rights (United States), the enquiry aimed to establish the extent and nature of violations of sexual and reproductive health rights and to recommend appropriate redress. Kenya is the only country to have launched a public enquiry of this kind.

Source: www.knchr.org/Portals/0/Reports/Reproductive_health_report.pdf.

Data collection and analysis

should be strengthened and made more systematic, especially with respect to data on younger girls

these data were “urgently needed,”¹¹⁰ but in December 2012 the General Assembly still had to call for the collection of data on “all forms of discrimination and violence against girls, especially forms that are under documented, such as female genital mutilations.”¹¹¹ It also called on States to develop unified methods and standards for the collection of age-disaggregated data and to develop additional indicators to effectively measure progress in eliminating FGM. It noted that these data should be disaggregated by sex, age and geographic location to provide a better understanding of the situations of girls, especially of the multiple forms of discrimination they face.

Where data collection and analysis surrounding FGM are already taking place, they should “be strengthened and made more systematic, especially with respect to data on younger girls,” according to a report of the Secretary-General. It noted that “[...] qualitative research should also be intensified to improve understanding of sociocultural factors that could facilitate abandonment and inform effective strategies to eliminate female genital mutilation.”¹¹²

5.2.5 Educational, training and awareness-raising programmes

Another recommendation is for introduction of appropriate educational and training programmes and awareness-raising campaigns, based on research findings about the problems arising from FGM. The objective is to systematically reach the general public and relevant professionals, including through the media, particularly television and radio discussion.¹¹³ The importance of education and the dissemination of information in raising awareness of FGM are emphasized in the Maputo Protocol¹¹⁴ and many UN human rights documents.¹¹⁵

Several monitoring bodies have also noted the need to continue and strengthen awareness-raising campaigns.¹¹⁶ The aim of such programmes is to change prevailing attitudes on gender roles and stereotypes that contribute to FGM.¹¹⁷ These programmes might help eliminate prejudices that hinder women’s equality and modify the social and cultural patterns of conduct of men and women.¹¹⁸ Campaigns are also needed to improve men’s understanding of their roles and responsibilities with regard to promoting the elimination of FGM.¹¹⁹

Governments should facilitate the establishment of multidisciplinary information and advice centers regarding the harmful aspects of FGM, as noted by the Committee on the Rights of the Child.¹²⁰ A recent General Assembly resolution provides the most elaborate explanation of government duties regarding education, training and awareness-raising. It calls upon countries to “enhance awareness-raising and formal, non-formal and informal education and training in order to promote the direct engagement of girls and boys, women and men and to ensure that all key actors, Government officials, including law enforcement and judicial personnel,

immigration officials, health-care providers, community and religious leaders, teachers, employers, media professionals and those directly working with girls, as well as parents, families and communities, to work to eliminate attitudes and harmful practices, in particular all forms of female genital mutilations, that negatively affect girls.”¹²¹ The General Assembly also called upon countries to strengthen advocacy and awareness-raising programmes and to mobilize girls and boys to take an active part in developing prevention and elimination programmes.¹²² It especially encouraged men and boys to take positive initiatives to combat FGM.

Empowering communities in Senegal

BOX 3

In Senegal, strengthening capacity on human rights in communities is a key element of efforts to raise awareness. During 2013, for example, 100 communities were trained by facilitators on topics such as democracy, human rights and responsibility, as well as problem-solving skills and health and hygiene. More than 6,500 men and women received training in four regions during the year.

Source: Senegal Country annual report, 2013, UNFPA-UNICEF Joint Programme on FGM/C.

5.2.6 Training of professionals

Adequate training for health care workers at all levels (nurses, midwives, doctors and other relevant personnel) on issues raised in the context of FGM is another recommendation.¹²³ Since FGM is a critical health issue for women, governments have been called on to ensure gender-sensitive training to enable health care workers to detect and manage the harmful consequences of the practice.¹²⁴ Training should also address the increased vulnerability of women and girls to HIV/AIDS and other sexually transmitted infections resulting from FGM, according to the General Assembly.¹²⁵ Governments have in addition been asked to ensure that social workers and medical personnel provide competent, supportive services and care to girls and women who are at risk or who have undergone FGM. Governments have also been urged to compel such personnel to report cases to the appropriate authorities when they believe girls or women are at risk.¹²⁶ The Secretary-General also called for governments to put in place effective sanctions to discourage health professionals from performing FGM.¹²⁷ The importance of training professionals is emphasized in many human rights documents.¹²⁸

5.2.7 Support for civil society organizations

As early as 1998 the General Assembly welcomed “the work carried out by non-governmental and community organizations in raising awareness of the harmful effects of female genital mutilation and other traditional

or customary practices affecting the health of women and girls.”¹²⁹ It also recommended that countries “give vigorous support” to the efforts of non-governmental and community organizations and religious institutions at national and local levels working to eliminate FGM. The importance of the work of NGOs is emphasized in several human rights documents.¹³⁰ The Special Rapporteur on violence against women called on governments to recognize the important role played by NGOs in working to eradicate FGM and to give them all necessary support and encouragement.¹³¹ In a 2002 report the Special Rapporteur noted that the “involvement of local women’s groups and civil society in the movement to eradicate harmful practices is the only guarantee that the practice will not re-emerge in the future.”¹³²

The ‘grandmother approach’ in Uganda

BOX 4

The ‘grandmother approach’ for social change was pioneered in the Amudat region of Uganda, where 50 grandmothers were trained to develop and deliver messages on FGM abandonment. In 2013 the grandmothers held 10 dialogues encouraging abandonment of FGM, reaching 114 girls. The programme is ongoing.

Source: Uganda country annual report 2013 of the UNFPA-UNICEF Joint Programme on FGM/C

5.2.8 Support services

The General Assembly has urged countries to protect and support women and girls who have been subjected to FGM and those at risk, including “by developing social and psychological support services and care” and taking “measures to improve their health, including sexual and reproductive health, in order to assist women and girls who are subjected to the practice.”¹³³

In addition, States are obliged to ensure that FGM does not interfere with access to prenatal and postnatal care and family planning.¹³⁴ States have been urged to develop age-appropriate safe and confidential programmes and medical, social and psychological support services to assist girls who are subjected to violence,¹³⁵ which should include counselling for women and men to discourage FGM.¹³⁶ Both the General Assembly¹³⁷ and the Special Rapporteur on violence against women have called for specialized shelter services for women and girls at risk of FGM. The report of the Special Rapporteur noted: “While shelters are generally associated with intimate partner violence, such sanctuary is also required by girls and young women escaping, for example, [...] female genital mutilation.”¹³⁸

5.2.9 Involvement of all actors

Also at the national level, governments have been called upon to ensure that key actors such as law enforcement personnel, judicial personnel and immigration officials, work together to eliminate FGM.¹³⁹ A December 2012

Medical services in Burkina Faso

BOX 5

Burkina Faso is one of the countries that offer services to women who have suffered FGM, especially to repair injuries caused by it. Since 2009, all district and regional hospitals have developed the skills of health providers to treat complications resulting from FGM. Medical supplies and kits to care for patients and promote the services in communities are an investment in improving the lives of girls and women. In 2013 227 girls and women have benefited from this treatment.

Source: Burkina Faso country annual report 2013 of the UNFPA-UNICEF Joint Programme on FGM/C

General Assembly resolution urged States to “pursue a comprehensive, culturally sensitive, systematic approach that incorporates a social perspective and is based on human rights and gender-equality principles in providing education and training to families, local community leaders and members of all professions relevant to the protection and empowerment of women and girls in order to increase awareness of and commitment to the elimination of female genital mutilations.”¹⁴⁰ Other human rights documents similarly mention the importance of a comprehensive, coordinated, systematic approach based on human rights; an integrated strategy for abandonment of FGM; and the involvement of multiple stakeholders at all levels.¹⁴¹

**Pursue a
comprehensive,
culturally
sensitive,
systematic
approach**

In addition States have been called upon to involve diverse actors in publicity campaigns, including public opinion leaders, educators, religious leaders, chiefs, traditional leaders (both community and religious), medical practitioners, teachers, women’s health and family planning organizations, social workers, health care providers, child care agencies, non-governmental organizations, arts organizations and the media. The objective is to promote both collective and individual awareness of the human rights of women and girls and of how harmful practices violate those rights. Groups and individuals working directly with girls, as well as parents, families and communities are also urged to participate in such campaigns.¹⁴²

The General Assembly has called on communities and religious and cultural groups and their leaders to be consulted in exploring alternatives to FGM.¹⁴³ The Secretary-General wrote that “The integral role of communities in the abandonment of female genital mutilation should be recognized and community-based abandonment initiatives supported.”¹⁴⁴

5.2.10 Social and economic reintegration of FGM practitioners

States have also been called upon to provide alternative training and education possibilities for traditional practitioners of FGM.¹⁴⁵ The Committee on the Rights of the Child and the Secretary-General recommend that States “provide retraining, where appropriate, for practitioners of female genital mutilation and support them to find alternative sources of income.”¹⁴⁶

CHAPTER SIX

Human Rights Monitoring Mechanisms

TREATY MONITORING BODIES

UNIVERSAL PERIODIC REVIEW

SPECIAL PROCEDURES



This chapter addresses recommendations in relation to FGM following from the human rights monitoring mechanisms directed to Burkina Faso, Egypt, Ethiopia, Kenya and Senegal.

6.1 Treaty Monitoring Bodies

Below, an overview is given of the concerns, recommendations and compliments following from the “concluding observations” of the UN Committee on the Rights of the Child (CRC) and the UN Committee on the Elimination of Discrimination against Women (CEDAW) in relation to the practice of FGM in Burkina Faso, Egypt, Ethiopia, Kenya and Senegal.

6.1.1 Burkina Faso

Burkina Faso has been commended by CEDAW for the various initiatives carried out by the National Committee to Combat the Practice of Excision and its campaign against FGM “which has resulted in a significant decrease in this practice.”¹⁴⁷ The CEDAW also welcomed the adoption of the National Gender Policy in July 2009, and the adoption of the National Action Plan for 2009-2013 “Zero Tolerance for Female Genital Mutilation.”¹⁴⁸ The CRC also commended the commitment at the highest levels of the Burkinabe’s State in the fight against FGM and the complementary initiatives undertaken, including the setting up of a national hotline.¹⁴⁹

Both the CEDAW and the CRC expressed their concerns about the continuing prevalence of FGM in Burkina Faso. The CEDAW reiterated that it remained “highly concerned that the practice continues to be widespread and is being performed with a higher degree of secrecy and at a younger age.”¹⁵⁰ The CRC also remained concerned at the continuing prevalence of FGM and the “low level of sanctions taken against those who subject children to genital mutilation.”¹⁵¹

Several recommendations were directed to the government of Burkina Faso in relation to FGM. The CEDAW recommended Burkina Faso to incorporate awareness-raising and educational campaigns addressed to women and men, girls and boys, religious and community leaders, parents, teachers and officials. It encouraged Burkina Faso to undertake such efforts in collaboration with civil society organizations, women’s groups and community and religious leaders. The CEDAW also recommended to eradicate FGM “explicitly recognizing that such practices should not violate human rights under any circumstances.”¹⁵² The CEDAW recommended Burkina Faso to effectively use innovative measures to strengthen understanding of the equality of women and men and, in particular, to develop outreach programmes for rural populations. The CEDAW encouraged Burkina Faso to increase its efforts to fully eradicate FGM and to carry on its robust public advocacy strategy, especially among parents and

traditional leaders so as to change traditional perceptions connected with this practice. The CEDAW also called upon Burkina Faso to bring offenders, including parents, to justice. The CRC recommended Burkina Faso to pursue its efforts to eradicate FGM throughout its territory, in particular by better coordinating anti-FGM related activities, ensuring that offenders are prosecuted and adequately punished and continuing awareness-raising efforts to change cultural perceptions connected with FGM. In addition, the CRC recommended reinforcing cooperation with neighboring countries in the region to combat FGM.¹⁵³

6.1.2 Egypt

Both the CRC and the CEDAW commended the criminalization of FGM¹⁵⁴ and measures taken in the context of the national campaign to counter this practice, including the “FGM-free village” projects.¹⁵⁵ The CRC acknowledged the significant awareness-raising efforts at national and village level to prevent and eradicate FGM in the framework of the National Programme to Combat Female Genital Mutilation.

Both the CRC and the CEDAW remain seriously concerned about the persistence and high prevalence of FGM in Egypt, “which is a grave violation of girls’ and women’s human rights and of the State party’s obligations under the Convention.”¹⁵⁶ In addition, the CEDAW noted with concern the serious health complications for girls and women arising out of this practice, “which in some cases may lead to death, and the impunity of perpetrators.”¹⁵⁷ In this respect, the CEDAW is concerned at the loophole in the current law that allows doctors to perform FGM if there is a “medical necessity.” The CRC is particularly concerned at impunity for perpetrators, as indicated in the low number of convictions of individuals performing FGM in violation of article 242 bis of the Penal Code, and at the strong correlation between FGM and poverty. The CRC further regrets that reporting cases of FGM is not mandatory under domestic law.

Both the CRC and the CEDAW recommended Egypt to strictly enforce the application of the criminalization of FGM, including through Law No. 126 of 2008, as well as the prosecution and adequate punishment of perpetrators of this practice. The CRC urged Egypt to making reporting on FGM mandatory, to encourage public reporting to and strengthening the monitoring of medical doctors by the Child Protection Committees, and ensure that medical doctors who practice FGM are prosecuted and punished in accordance with law.¹⁵⁸ The CEDAW recommends that the State party continue and increase its awareness-raising and educational efforts targeted at both men and women, with the support of civil society organizations and religious authorities, in order to completely eliminate the practice and its underlying cultural justifications. Such efforts should

Address the
**loophole in
the current law**
that allows doctors
to perform FGM
if there is a
“medical necessity.”

include the design and implementation of effective educational campaigns to combat traditional and family pressures in favour of this practice, particularly among those who are illiterate, especially parents.¹⁵⁹ Similarly, the CRC urged Egypt to develop sensitization programmes to foster positive change in underlying social norms, value systems and attitudes which may contribute to the practice of FGM, targeting households, local authorities, religious leaders and medical practitioners as well as judges and prosecutors. The CRC further recommends that Egypt consider adopting a programme on alternative income for those performing FGM, and ensure that the awareness-raising programme at village level conducted in the National Programme to Combat FGM is extended throughout the country.

6.1.3 Ethiopia

Both the CRC and CEDAW welcomed Ethiopia's efforts to combat FGM by, for example, the adoption of the new Criminal Code of 2005, which criminalizes various forms of VAW including FGM and established special investigation and prosecution units and victim-friendly benches in the federal court system.¹⁶⁰ The CRC noted with appreciation the efforts undertaken by the National Committee on Harmful Traditional Practices in Ethiopia to document and combat FGM.¹⁶¹ The CEDAW also noted that FGM is declining among younger women and in urban areas.

Both the CRC and the CEDAW are concerned that FGM remains highly prevalent in rural and pastoralist areas in Ethiopia (with the highest rates in the Afar (91.6 per cent) and Somali (79 per cent) regions). The CEDAW is also concerned that the penalties for FGM stipulated in articles 561-563, 567, 569 and 570 of the Criminal Code (2005) are too lenient. The CEDAW is further more concerned that FGM cases are underreported owing to cultural taboos and victims' lack of trust in the legal system, and that criminal law provisions are not consistently enforced because of insufficient allocation of funds, lack of coordination among the relevant actors, low awareness of existing laws and policies on the part of law enforcement officials, lack of capacity to apply the law in a gender-sensitive manner and discriminatory societal attitudes. In addition, the CEDAW is concerned about the persistence of adverse cultural norms, practices and traditions as well as patriarchal attitudes and deep-rooted stereotypes regarding the roles, responsibilities and identities of women and men in all spheres of life. It notes that such stereotypes also contribute to the persistence of FGM.¹⁶²

FGM cases are underreported

owing to
cultural taboos

The CEDAW recommended Ethiopia to Amend the Criminal Code (2005), with a view to increasing the penalties for female genital mutilation in articles 561-562, 567, 569 and 570. Furthermore, both the CRC and the CEDAW urged Ethiopia to effectively enforce the provisions of the Criminal Code (2005) regarding FGM, prosecute such acts upon complaint by the victim or ex officio, and impose appropriate penalties

commensurate with the gravity of the crime on perpetrators. The CEDAW also recommends Ethiopia to provide mandatory training to judges, including local and sharia court judges, prosecutors and the police on the strict application of the FGM provisions of the Criminal Code. In addition, the CEDAW encouraged women and girls to report acts of violence to the competent authorities, by continuing to raise awareness about the criminal nature and harmful effects of FGM on their health, eradicating the underlying cultural justifications of such violence and practices, destigmatizing victims, and training law enforcement and medical personnel on standardized, gender-sensitive procedures for dealing with victims and effectively investigating their complaints. The CEDAW also urged Ethiopia to collect disaggregated data on the number of complaints against, prosecutions or convictions of, and sentences imposed on perpetrators of FGM, and provide such data to the Committee.¹⁶³

The CRC recommended that Ethiopia adopts a comprehensive strategy to prevent and combat harmful traditional practices and ensure resources for its implementation, in particular in rural areas. Awareness-raising campaigns on the negative effects on the health of children, especially girls, should – according to the CRC – be conducted for the general public as well as community, traditional and religious leaders. The CRC further recommends that Ethiopia provides retraining, where appropriate, for practitioners of FGM and support them to find alternative sources of income.¹⁶⁴

6.1.4 Kenya

The CEDAW welcomed the adoption of a National Plan of Action (2008–2012) and the approval of a National Policy for the Abandonment of Female Genital Mutilation in June 2010. The CRC acknowledged the endeavors made by local administrative officers in collaboration with civil society to protect the girl child from FGM, particularly the prohibition of FGM under the Children’s Act of 2001 and the implementation of the Alternative Rite of Passage Initiative.¹⁶⁵

Both the CEDAW and the CRC reiterated their concern that FGM is still widely practiced, especially among certain indigenous and minority groups.¹⁶⁶ The CEDAW reiterated its concern at the persistence of adverse cultural norms, practices and traditions as well as patriarchal attitudes and deep-rooted stereotypes regarding the roles, responsibilities and identities of women and men in all spheres of life. The CEDAW is concerned that such customs and practices perpetuate discrimination against women, and are reflected in women’s disadvantageous and unequal status in many areas, including in public life and decision-making and in marriage and family relations. The CEDAW noted that such stereotypes also contribute to the persistence of violence against women as well as harmful practices, including FGM. Furthermore, the CEDAW expressed its concern that

Criminal law provisions are not consistently enforced because of insufficient allocation of funds, lack of coordination among actors, low awareness of existing laws.



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despite such negative impacts on women, Kenya has not taken sustained and systematic action to modify or eliminate stereotypes and negative cultural values and harmful practices.¹⁶⁷ The CEDAW also noted with concern that despite the enactment of the Children's Act (2001) which prohibits FGM, girls are increasingly subjected to FGM at younger ages than previously. It is further concerned that this practice has not been prohibited for women over 18 years.¹⁶⁸

The CEDAW recommended Kenya to put in place, without delay, a comprehensive strategy to modify or eliminate harmful practices and stereotypes that discriminate against women, in conformity with articles 2 (f) and 5 (a) of the Convention. Such measures should include efforts, in collaboration with civil society, to educate and raise awareness of this subject, targeting women and men at all levels of society, including traditional leaders. In addition, the CEDAW urged Kenya to address FGM by instituting public education programmes and enforcing prohibition of those practices; and to use innovative measures to strengthen understanding of the equality of women and men including working with the media to enhance a positive and non-stereotypical portrayal of women. In addition, the CEDAW recommended Kenya to ensure the effective implementation of the 2001 Children's Act which outlaws FGM for girls under 18 years, as well as prosecution and punishment of perpetrators of the practice, to take all necessary measures to expedite the enactment of the Prohibition of Female Genital Mutilation Bill (2010) which will, inter alia, outlaw the

practice for all women; to continue and increase its awareness-raising and education efforts targeting families, practitioners and medical personnel, with the support of civil society organizations and religious authorities, in order to completely eliminate FGM and its underlying cultural justifications; and to establish support services to meet the health and psychosocial needs of women and girls who are victims of this practice.¹⁶⁹ The CRC recommended Kenya to strengthen its measures regarding FGM and ensure that the prohibition is strictly enforced; to conduct awareness-raising campaigns to combat and eradicate FGM; to introduce sensitization programmes for practitioners and the general public to encourage change in traditional attitudes, and engage the extended family and the traditional and religious leaders in these actions.

6.1.5 Senegal

Senegal has also been commended by the Treaty Monitoring Bodies for its efforts in the fight against FGM. The CRC took notes of the progress made by Senegal in the effort to bring domestic law into compliance with the Convention¹⁷¹ and welcomed the enactment of Law No. 99-05 of 1999 prohibiting FGM.¹⁷² The CRC noted with appreciation the efforts made by Senegal in combating FGM.¹⁷³

Both the CEDAW and the CRC expressed their concerns about the persistence of FGM in Senegal. The CRC was concerned that “some traditional cultural attitudes towards children may hamper the full enjoyment of the rights embodied in the Convention by children in Senegal. An understanding of children as subjects of rights has not yet penetrated all strata of Senegalese society.”¹⁷⁴ The CRC remained concerned by the continuous impact of FGM, which hampers the implementation of the Convention.¹⁷⁵

The CEDAW and CRC made several recommendations to the Senegalese government in relation to FGM. In 1997, before the national law that criminalizes FGM was adopted, the CRC recommended that Senegal should ensure that national legislation conforms fully to the provisions and principles of the Convention of the Rights of the Child and that “specific provisions should be included with a view to clearly forbidding female genital mutilation.”¹⁷⁶ In addition, the CRC recommended that adequate legislative and other measures should also be taken to establish a complaints procedure for children whose fundamental rights have been violated.¹⁷⁷ The CEDAW encouraged Senegal in 1994 to “step up its public information campaigns on behalf of women and to expand its programmes to combat traditional practices which affect women’s health and advancement in order to eliminate persistent forms of discrimination against women.”¹⁷⁸ The CRC encouraged the Government to “pursue its efforts aiming at promoting advocacy and awareness and understanding

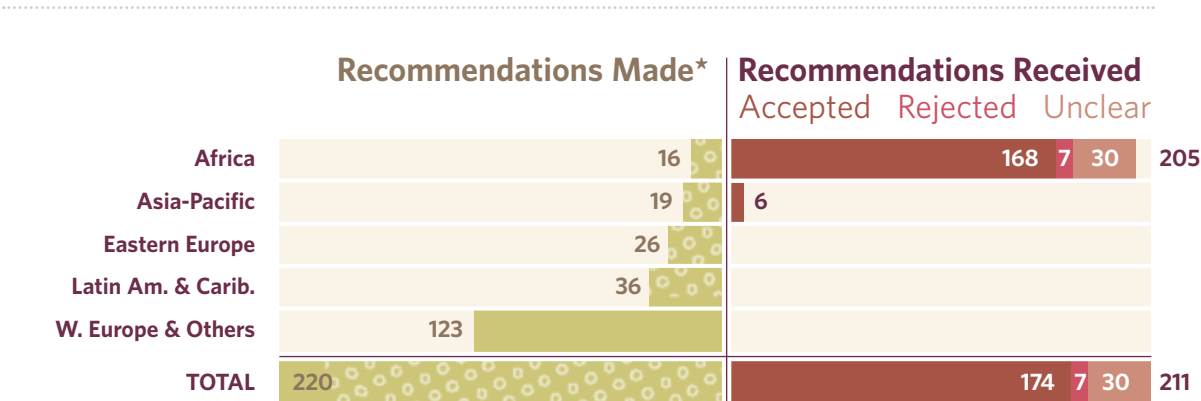
of the Convention and having its basic principles grasped by the general public, in particular by ensuring the translation of the Convention in all national languages and paying particular attention to people living in rural areas. The Government should pursue such efforts in close cooperation with community and religious leaders, with a view to promoting change in persisting negative attitudes towards children, particularly girls, and to abolishing practices prejudicial to the health of children, in particular female genital mutilations.”¹⁷⁹ More concretely, the CRC recommended Senegal to (a) continue with awareness-raising campaigns to combat and eradicate FGM; (b) to introduce education and awareness-raising programmes for practitioners and the general public to encourage change in traditional attitudes and discourage harmful practices, engaging with the extended family and the traditional and religious leaders and support practitioners of female genital mutilation to find alternative sources of income; and (c) to ensure the implementation of the Law No. 99-05 regarding the prohibition of FGM and ensure that perpetrators are brought to justice.¹⁸⁰

6.2 Universal Periodic Review (UPR)

During the first cycle of the UPR, 211 recommendations were made on FGM. Approximately 120 recommendations focused on reviewing, enacting and implementing laws and policies, and more than 40 on conducting awareness-raising campaigns. A number of the remaining recommendations were general in nature, asking the State under review to “take measures” or “promote efforts” to address the issue. An example of a robust recommendation is the following: “Adopt and implement legislation prohibiting FGM, and ensure that offenders are prosecuted and punished, and take legal and education measures to combat this practice.”¹⁸¹

Regional performance on FGM recommendations
made during the first cycle of the UPR

FIGURE 2



*Excluding the State of Palestine and the Holy See.

Examples of recommendations on tackling FGM made under the Universal Periodic Review

TABLE 1

General recommendations	"Continue its initiative to combat and put an end to the practice of excision"
	"Continue to fight against FGM"
	"Take appropriate and efficient measures with the view to ending the practice of female genital mutilation"
	"Maintain and reinforce all measures aimed at eradicating female genital mutilation, which is often related to other forms of aggression against women"
Legislation	"Continue and increase efforts to eradicate female genital mutilation (FGM) throughout the country; bring perpetrators to justice and ensure adequate punishment"
	"Continue its efforts to eradicate female genital mutilation and strengthen implementation of its laws and administrative decisions criminalizing its perpetrators"
	"Make all efforts to take the necessary measures to ensure that there is an effective prohibition of female genital mutilation"
	"Urgently adopt legislation criminalizing female genital mutilation, and train members of the police, prosecutors and judges on the strict application of laws and regulations to be adopted in this field"
	"Prosecute and punish persons who, despite awareness campaigns, continue to be perpetrators or accomplices of FGM, according to the law of 22 January 1999"
National Action Plan	"Further pursue the national strategy and the action plan on the elimination of harmful traditional practices and FGM"
	"Continue its efforts to achieve the goals of the second national Plan to eliminate excision (2012-2015)"
	"Continue its positive engagement toward the total eradication of excision by 2015 as indicated in national Action Plan"
Awareness raising	"In order to eradicate FGM, increase public advocacy and training of judiciary and public officials, traditional leaders and parents, both men and women"
	"Step up efforts to ensure the effective implementation of the ban on FGM, in particular through the implementation of preventive measures such as the dissemination of information and awareness-raising among populations at risk"
	"Ensure strict criminalization of female genital mutilation and carrying out awareness-raising to eradicate its acceptability among the public"
Involvement stakeholders	"Pursue a regular dialogue with the stakeholders in various communities nationwide, including the village chiefs, religious leaders, men and boys as well as civil society in order to promote a better understanding of the importance of equality between women and men and to identify practical means of putting an end to harmful practices against women and girls including FGM"
	"Intensify efforts in the direction of sensitizing all stakeholders to prevent FGM"
Prevention	"Increase the resources devoted to the prevention of violence against women and of FGM"
Lessons learned	"Continue its efforts to eradicate the practice of FGM by, for example, looking at the lessons learned by other countries in the region that are dealing with this issue"



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A large number of the recommendations, 174, were accepted by the country to which they were directed (see table 1). Thirty recommendations received unclear responses from six States. Seven recommendations were rejected, by two States that denied that FGM was practiced in their countries. In both cases, the compilation of information reflected concerns raised by treaty bodies about the existence of the practice.

6.3 Special Procedures

Recommendations extracted from some of the reports of Special Rapporteurs with reference to FGM, violence against women and harmful practices for few countries.

In general, the recommendations for States by the different human rights mechanisms provide a strong basis and justification for interventions aimed at enhancing the accountability of States as a duty bearer within a human rights perspective in addition to also informing the focus and content of programmatic interventions designed to protect girls and women from FGM and provide appropriate care services. Hence, there is a need to be systematic and design ways to make use of the recommendations for States by the different human rights mechanisms. In addition, efforts should also be exerted to make inputs into and inform the preparation of reports generated through the various human rights mechanisms.

Examples of recommendations addressing FGM by Reports of the Special Rapporteurs on various thematic areas

TABLE 2

TYPE OF REPORT	RECOMMENDATION
Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health	"expand existing and seek new methods of enforcing laws prohibiting harmful "traditional practices," especially those that discriminate against women, including trokosi and female genital mutilation"
Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment	"establish effective mechanisms to enforce the prohibition of violence against women, including traditional practices such as female genital mutilation, continue to organize awareness-raising campaigns and conduct a study to assess the prevalence of female genital mutilation"
Report of the Special Rapporteur on the situation of human rights and fundamental freedoms of indigenous people	"the government should reinforce its efforts to achieve the effective eradication of FGM in all communities, by helping promote culturally appropriate solutions such as alternative rites of passage and supporting women's organizations in these tasks"
Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment	"establish effective mechanisms to enforce the prohibition of violence against women including traditional practices, such as FGM, and continue awareness raising campaigns to eradicate such practices, and expedite the adoption of the violence against women bill"

CHAPTER SEVEN

Implementation of the Human Rights Framework by Five States

RATIFICATION OF INTERNATIONAL INSTRUMENTS

NATIONAL LAWS

POLICIES AND NATIONAL ACTION PLANS

AWARENESS-RAISING

DATA COLLECTION

TRAINING

STATE SUPPORT TO NGOS AND RELIGIOUS AND TRADITIONAL LEADERS

ALTERNATIVES TO FGM

COMPREHENSIVE AND COORDINATED APPROACH

FINANCIAL SUPPORT



Although the United Nations and the African Union have played a significant role in recognizing FGM as a human rights violation, the challenge of ending the practice ultimately depends on action at national level. This chapter examines the implementation of the international and regional human rights framework in five countries: Burkina Faso, Egypt, Ethiopia, Kenya and Senegal.

7.1 Ratification of international instruments

As shown in table 6, three of the five countries have ratified the relevant international and regional human rights treaties. Ethiopia has signed but not yet ratified the Maputo Protocol, and Egypt has not signed or ratified it. This means that these two countries are not bound by the legal provisions set forth in the protocol.

Ratification of international instruments relevant to FGM
in selected countries

TABLE 3

	Convention on the Elimination of All Forms of Discrimination against Women	Convention on the Rights of the Child	Maputo Protocol	African Charter on Human and People's Rights	African Charter on the Rights and Welfare of the Child
Burkina Faso	14 Oct 1987	31 Aug 1990	9 Jun 2006	7 Jun 1984	8 Jun 1992
Egypt	18 Sep 1981	6 Jul 1990	Neither signed nor ratified	20 Mar 1984	9 May 2001
Ethiopia	10 Sep 1981	14 May 1991	Signed 1 Jun 2004, not ratified	15 Jun 1998	2 Oct 2002
Kenya	9 Mar 1984	11 Dec 1995	13 Oct 2010	23 Jan 1992	25 Jul 2000
Senegal	5 Feb 1985	31 Jul 1990	27 Dec 2004	13 Aug 1982	29 Sep 1998

Note: Date provided is date of ratification unless otherwise indicated.
Source: <https://treaties.un.org/Home.aspx?lang=en> and www.achpr.org/instruments/.

7.2 National laws

7.2.1 Constitutions

All five of the countries have a constitutional guarantee or statutory recognition of the rights of women and girls. However, only Ethiopia's Constitution in addition specifically protects women from bodily harm and harmful customs, laws and practices. Article 4 of Ethiopia's Constitution says, "Women have the right to protection by the state from harmful customs, laws and practices that oppress them and cause bodily or mental harm to them are prohibited." The constitutions of Burkina Faso, Egypt, Kenya and Senegal do not specifically address harmful practices.

7.2.2 Legislation prohibiting FGM

All five countries have passed legislation criminalizing the practice of FGM. Kenya has the most recently passed and most elaborate law. In 2011 the Government adopted the Prohibition of Female Genital Mutilation Act, drafted by the Kenya Women's Parliamentary Association. It mandates a sentence of three to seven years or a fine of Ksh 500,000 (nearly \$6,000) for anyone practicing FGM, including traditional practitioners, parents, doctors and nurses – even the person who supplies the premises or the knife. The same penalties also apply to anyone convicted of bringing a girl into Kenya from abroad to be cut; hiring a person to perform FGM; failing to report an incident of FGM; or carrying it out on a Kenyan in another country. The act provides for entry by law enforcers into premises where they suspect FGM is being carried out. Realizing the act in Kenya was a long process and required employing various strategies at different levels (see box 6).

The law specifies revocation of licenses of medical practitioners performing the procedure. If a girl dies as a result of a procedure (due to infection, excessive bleeding, etc.), the sentence for anyone directly involved can be life in prison. The act clearly states that individuals cannot avoid prosecution by claiming that FGM is a cultural or religious custom or practice and that the victim gave consent to be cut. The law also prohibits the use of derogatory or abusive language to harm a woman/girl for not having undergone FGM or a man for marrying/supporting a girl who has not undergone the practice. It also established the anti-FGM Board to implement and monitor the law. Supported by the Government, it draws its members from relevant ministries.

Senegal amended its Penal Code to prohibit FGM in 1999. Punishment for participation calls for imprisonment from six months to five years (Law 99-05, Article 299 bis). The maximum punishment applies when FGM has been practiced or facilitated by a member of the medical or paramedical profession. The law requires hard labor for life if the girl dies. The same

Supporting legislation that criminalizes the practice of FGM in Kenya

BOX 6

In 2008, UNFPA provided technical and financial assistance to the Ministry of Gender, Children and Social Development to conduct a national study on FGM that led to the creation of an FGM/C National Secretariat. The Secretariat played a pivotal role in coordinating the efforts of various stakeholders and in the formulation of a national policy on FGM that paved the way to drafting the Prohibition of FGM Bill 2010. On October 7, 2011, Kenya's President signed into law the Prohibition of FGM Act 2011, which for the first time unequivocally criminalized FGM in Kenya. The journey to passing the act was long and employed a number of strategies: advocacy and mobilization of parliamentarians, community and religious leaders, women lawyers, medical professional associations and youth; high visibility of and active support by male parliamentarians; personal testimony by women parliamentarians from practicing ethnic groups; education workshops and dialogues between communities, civil society and government entities; and widespread media campaigns that stressed the human rights aspects and adverse health consequences of FGM.

Source: UNFPA-UNICEF Joint Programme on FGM/C Annual Report 2012.

penalties apply to any person who, through gifts, promises, influence, threat, intimidation or abuse of authority or power, causes FGM to take place or instructs others to practice it.

In 1996, the Government of Burkina Faso adopted a penal code (Law No. 043/96/ADP) prohibiting the practice of FGM. Article 380 stipulates that anyone who violates or attempts to violate the physical integrity of female genital organs by means of total removal, excision, infibulation, numbing or any other means shall be punished by a term of imprisonment of six months to three years and/or a fine of CFA 150,000 to 900,000 (between \$300 and \$1,800). If the procedure leads to death, the sentence is imprisonment for 5 to 10 years. Articles 381 and 382 stipulate the maximum punishment for medical professionals who perform FGM and the possibility of disbarment from practice by the courts for up to five years. Anyone having knowledge of the FGM action who does not notify the authorities is to be punished by a fine of CFA francs 50,000 to 100,000 (around \$100 to \$200).

In revising its Criminal Code in 2005,¹⁸² Ethiopia criminalized several harmful practices, including FGM, in articles 565, 566 and 567. Whoever circumcises a woman of any age is punishable with simple imprisonment for not less than three months, or a fine not less than 500 Birr (around \$25). Infibulation of the female genitals is punishable with rigorous imprisonment from three to five years. Where injury to body or health has resulted from the act of FGM, the penalty is more severe: rigorous imprisonment from 5 years to 10 years.

FGM is criminalized in Egypt in Penal Code 242. The law stipulates imprisonment of FGM practitioners for three months to two years, or a fine of 1,000 to 5,000 pounds (around \$150 to \$725).

7.2.3 Court cases

The government of Burkina Faso has shown strong political commitment by implementing national legal instruments against FGM, resulting in a relatively large number of court cases (see box 7). Between 1997 and 2005, 94 individuals (traditional practitioners and parents) were sentenced for violating the law. From 2005 through 2009, the number increased to 686 (40 traditional practitioners and 646 parents). Since 2009, 109 FGM cases have been recorded, 278 individuals have been prosecuted and 190 have been convicted.

FGM court cases in Burkina Faso

BOX 7

The courts in Burkina Faso do not hesitate to sentence people found guilty of practicing FGM on under-age girls. Such arrests are usually the result of anonymous tips. As early as 1990 the Government established a national telephone hotline, the 'Green Phone: SOS Excision', to encourage people to report cases of FGM, even though the practice was not illegal at that time. Today, such reports serve as the basis for legal interventions and prosecutions. Information about the hotline is disseminated on radio and television, in newspapers, on posters, at public events, in street theatre and door to door by the police.

"In the last few years many more people have been reporting cases of FGM," said Permanent Secretary of the National Committee to Fight the Practice of Excision (SP/CNLPE). "This doesn't mean that more people are practicing FGM, but that more people are aware of the harm caused by the practice and are reporting cases. In the past they didn't speak up because FGM is considered a family matter and there is a sense of family and community solidarity. People were afraid they would be treated as social outcasts if they reported cases. But recently we've had many reports from around the whole country, especially from areas where people never reported this before, where there used to be a code of silence surrounding this issue."

In 2009, 203 cases of FGM were reported. Callers to the hotline tend to be women, educated individuals and young people. Cases are also reported at police stations or customs offices, through religious leaders and local administrators, or directly to the SP/CNLPE. When an informant reports that the procedure is about to be carried out, the police go to the scene to halt it. They tell the family that FGM is against the law and explain why it is harmful. If the procedure has already been carried out, they take the child to a health clinic for medical examination and treatment. Meanwhile, the police create a case file, which then starts on its path through the justice system.

Source: UNFPA-UNICEF Joint Programme on FGM/C 'Burkina Faso has a strong law against FGM, but winning hearts and minds remains crucial'. See www.unfpa.org/gender/docs/fgmc_kit/burkinafaso.pdf.

Few other countries have systematic, reliable and comprehensive data. There have been around 25 cases in Egypt since the law was issued in 2008, with 5 convictions. In Senegal there have been 7 court cases, but only 1 conviction. In Kenya 7 cases were reported to the police, 3 cases went to court and 1 was prosecuted. In Ethiopia, 13 cases violating national FGM laws were prosecuted in 2013, compared to 1 case in 2012.¹⁸³

7.2.4 Capacity and financial resources

In all five countries, law enforcement mechanisms are in place to monitor implementation of the legislative framework. However, they all face two critical issues: inadequate capacity and insufficient resources allocated for implementation of the laws. None of the countries has sufficient government funding to cover the costs. Governments need to mobilize more funds dedicated to abandonment of FGM in order to strengthen the mechanism to enforce the law.

7.3 Policies and national action plans

A national plan of action and health or gender-related policies has been formulated in all five countries to promote the abandonment of FGM and other harmful practices. These plans, policies and other strategic interventions were developed to implement and enforce national laws banning the practice of FGM.

In Ethiopia, the Government promotes the abandonment of harmful practices in a number of national policies covering population, health and women's issues. The National Policy on Women, developed in 1993, was strengthened in October 2005, when the Women's Affairs Office, which previously came under the Office of the Prime Minister, became a line ministry. In 2006, the Committee on the Rights of the Child argued that "a comprehensive strategy to counteract harmful traditional practices has not been developed,"¹⁸⁴ and it recommended that Ethiopia adopt such a strategy. In December 2008, an inter-ministerial body was established to prevent and respond to gender-based violence, including FGM and other harmful practices.

An inter-ministerial body was established to prevent and respond to gender-based violence, including FGM

In Senegal, the Government incorporated provisions to end FGM into a broader national policy framework that includes the National Programme for Reproductive Health (1997-2001), National Health and Social Development Programme (1998-2007), Plan of Action for Women (1997-2001) and Poverty Reduction Strategy Paper (2006-2010). In 2000, the Ministry of the Family and National Solidarity developed the National Plan of Action for the Abandonment of FGM (2000-2005) to coordinate efforts to abandon the practice. In February 2010, a new national action plan was adopted for 2010-2015 (see box 8).

Human rights-based plan of action: Senegal

BOX 8

In the 2010-2015 National Action Plan, the Government of Senegal officially endorsed the human rights-based, community empowerment approach as the preferred strategy for community-level engagement. Empowerment through educating people on human rights is an essential component of the new policy. This strategic decision follows the evaluation of the first national plan of action (2000-2005), which showed the impact of this mechanism. The approach refers to fundamental human rights, the concept of cultural sensitivity and commitment by rights-holders. It requires the free and genuine participation of those affected and calls for special attention to non-discrimination, equality and fairness.

Source: Ministry of Family Government of Senegal, National Plan of Action 2010-2015, Dakar Senegal 2009.

Policies and action plans have also been put in place in Kenya to address FGM. They include the 2007 National Reproductive Health Policy, with the theme of 'enhancing reproductive health status for all Kenyans'; the National Plan of Action for the Elimination of Female Genital Mutilation in Kenya (2008-2012) and the Adolescent and Reproductive Health Policy and Plan of Action (2005-2015). The need for a comprehensive policy framework specifically addressing FGM led to formulation of the National Policy for the Abandonment of FGM (2008-2012), approved by the Cabinet in June 2010. The policy was instrumental in the formulation of a new law known as the Prohibition of FGM Act 2011.

Burkina Faso has enjoyed strong government support for abandonment of FGM for many years. It established a policy to end the practice in the early 1980s and continues to advocate strongly against it. The national plan on FGM involves advocates from several important sectors of society: religious leaders, the police force, medical professionals, teachers and youth and women's organizations. In 2003 Burkina Faso began implementing an integrated communication plan, in which the SP/CNLPE broadcasts information about harmful practices including FGM over regional and provincial radio stations. The plan provides training for volunteers who discuss the consequences of FGM with communities as part of efforts to persuade them to abandon the practice. The five volunteers in each community include two women and a representative of the local traditional authority, a local youth group and a local NGO. This has ensured that messages are broadly disseminated to a wide range of groups.

In Egypt the action plan to combat FGM is focused on a project, the FGM-Free Village Model, spearheaded by the National Council for Childhood and Motherhood in collaboration with a consortium of donors

The approach refers to fundamental human rights, the concept of **cultural sensitivity** and commitment by rights-holders.

and UN partners. The project aims to eliminate the social pressure to cut, targeting all community members in 120 villages throughout Upper and Lower Egypt. It was designed to empower girls and their families to make a well-informed choice to abandon FGM. The project works with communities as a whole, instead of individual families or specific target groups, to create an environment conducive to dialogue. The idea is for influential groups (community leaders, teachers, mothers, midwives, youth and men) to support families to abandon the practice.

7.4 Awareness-raising

All five countries have been successful in using diverse communication media to reach a broad audience, from cities to remote rural areas (see box 9). The tools include press releases and radio and television programmes, such as soap operas, talk shows, panel discussions and phone-ins in local languages. Social media such as Facebook and Twitter have provided rich opportunities for discussion and dialogue, especially among young people and adolescents. In Kenya, young women and men are sharing information and discussing FGM with their Facebook friends and peers.

In raising people's awareness and breaking the silence around FGM, the countries have worked closely with national and local media to bring the issue into the public realm, encouraging change in social norms. Media events take place in every country throughout the year, especially during celebrations of the annual International Day of Zero Tolerance of FGM. Media coverage of large-scale public declarations of abandonment of the practice have been documented in Egypt and Ethiopia and widely disseminated.

Awareness-raising takes place at the grass-roots level through community education sessions in all five countries. The curriculum covers issues ranging from fundamental human rights, such as the right to bodily integrity and the right to be protected against all forms of discrimination, to women's health and the health consequences of FGM. Participants are engaged through group discussions, role-playing, theatre, poetry and song. In Senegal, a bold course on FGM, probably the first of its kind anywhere, has been integrated into high school and college curricula. Aimed at students aged 10-19, the course covers the different forms of FGM, the health and psychological effects of the practice, and the human rights that apply to girls' physical integrity, among other topics.



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Diverse communication for sensitization on FGM

BOX 9

Radio programmes: In Burkina Faso, an estimated 350,000 people listened to 840 radio programmes discussing FGM in three local languages. The broadcasts consisted of interviews with a panel of religious and traditional leaders and officials of the justice system, who discussed the consequences of FGM in the short, medium and long term; the possibility of repairing damage caused by the practice; anti-FGM legislation; and complications from FGM during childbirth.

Media dialogues: In Ethiopia three media dialogues were conducted at the community level in Afar and broadcast on regional radio in the local language. Members of the media, religious leaders and government officials discussed the impacts of FGM on the health of women and girls. At the end of the dialogues, the media participants expressed their commitment to continue reporting on the issue. In addition, a radio spot about FGM was transmitted every day for 100 days on the regional radio station in Afar. The official declarations of two Afar districts to abandon FGM were covered by several media outlets including the national network, Afar TV, two regional radio stations and local newspapers.

Engagement with school teachers: Teachers in Kenya are proving to be highly effective, dedicated advocates against FGM. The Joint Programme supported the NGO Women Empowerment Link to conduct a training of trainers for 31 primary school teachers on how to work with students and parents to prevent FGM. Once trained, the teachers organized forums on FGM, gender-based violence and human rights for parents, teachers and students aged 12 to 15, the age when girls in this area often undergo FGM.

Source: UNFPA-UNICEF Joint Programme on FGM/C: Accelerating Change, Annual Report 2011.

7.5 Data collection

Since 2000, the governments of the five countries, in collaboration with partners, have carried out national household surveys to collect data on FGM. The tools have been Demographic and Health Surveys (DHS), which are typically, conducted every five years, and Multiple Indicator Cluster Surveys (MICS). These surveys provide data on national prevalence rates, the distribution of the practice within countries and the circumstances surrounding it.¹⁸⁵ DHS has been conducted in all five countries and twice in Ethiopia and Kenya, while MICS have been carried out in Burkina Faso and Senegal. Studies have also been carried out in these countries, including those focusing on the social conventions and norms that uphold FGM, along with quantitative and qualitative research and knowledge, attitudes and practices surveys. These sources of information have been vital tools for formulating national action plans and designing FGM programmes.

Some government bodies, such as ministries of health, also collect data. In Burkina Faso, several initiatives have been taken to generate additional supplementary data on FGM. Under a pilot project in several rural areas, medical staff collected data using the biomedical observation method. In Ethiopia, on the other hand, registration cards for pregnant women record medical history, antenatal check-ups, delivery and postnatal check-ups. The cards serve as a mechanism to follow up on the status of newborn baby girls. In addition, a survey conducted in seven regions collected data on knowledge, attitudes and practices related to violence against women and FGM levels among practicing groups.

All five countries recognize the importance of developing more human rights-based and culturally sensitive monitoring and evaluation systems. They have expressed the need to invest in systematic monitoring and evaluation to identify high-prevalence areas that require further assistance and to respond to specific contexts through appropriate interventions.

7.6 Training

Training of health care professionals is taking place in all five countries, reflecting understanding of the important role of public health services in preventing FGM and mitigating its harmful effects on women's health. The training includes the clinical management of FGM and reproductive health-related complications, as well as promotion of its abandonment. The antenatal period is a particularly timely opportunity to provide information to women and other family members about the health consequences of FGM.

In countries such as Burkina Faso, health care providers in remote areas have been trained to provide better treatment for women suffering the effects of the FGM procedure. In Senegal, health workers have been trained

on the human rights approach to FGM, enabling them to support community efforts to abandon the practice. In Egypt, Ethiopia and Kenya, where families seeking the FGM procedure go to doctors and other trained health professionals, training has been provided to health care providers. It includes comprehensive information about FGM and why it should be stopped, as well as technical knowledge about how to care for girls and women suffering complications of it. The training also addresses how to resist requests for FGM and counsel patients to abandon the practice. In Egypt, the State has developed strategies to curtail the practice (see box 10).

Professionals in the justice system are also being trained to implement laws against FGM. In 2012, a number of judges, prosecutors, lawyers, magistrates and police probation officers in Ethiopia, Kenya and Senegal were trained in the enforcement of their respective laws. In Senegal, a work plan was developed by the Ministry of Justice to inform the public and better apply the law, in collaboration with key stakeholders across 14 regions. The Ministry of the Family organized workshops across the country to encourage implementation of the law. These were attended by administrative authorities, local elected officials and representatives of community-based organizations.

State efforts to curtail medicalization of FGM in Egypt

BOX 10

The term 'medicalization' is used to describe cases in which FGM is performed by medical providers. In Egypt, a 2012 survey of health professionals revealed that medicalization still poses a major threat to abandonment of FGM. Survey results showed that health care providers appeared to still be susceptible to the traditional mythology surrounding the practice, rather than current scientific evidence. As demand persists, health care providers are also tempted by the additional income.

To enforce the medical ethical principle to safeguard the health of the people, the Ministry of Health and the Ministry of State for Family and Population have devised various strategies to prevent and end the medicalization of FGM. These include provision of a training manual and a question-and-answer booklet for health care practitioners, which have been mainstreamed into the pre-service training programme for physicians. A trainer's manual was developed for doctors in public hospitals and health units. A monitoring surveillance system that includes an anonymous reporting mechanism has also been developed to report doctors who continue to perform FGM despite the law against the practice, especially at private clinics.

Source: UNFPA-UNICEF Joint Programme on FGM/C, Annual Report 2012.

7.7 State support to NGOs and religious and traditional leaders

To accelerate abandonment of FGM, the five countries have been supporting partnerships among stakeholders, particularly NGOs, faith-based organizations and religious and traditional leaders. In the Gusii community in Kenya, where rates of FGM are among the highest in the country (at 96 per cent), traditional elders have made a public declaration on the abandonment of FGM. In Ethiopia, a regional network of NGOs and civil society groups has been established to advocate against harmful practices, including FGM. In Burkina Faso the Human Rights Network and FGM has been formed (see box 11). In Egypt, a local NGO, Childhood Development Association, has worked with a partner to design a manual for advocacy leaders on changing harmful practices through peer education using the latest techniques and youth-specific messages. A leading NGO partner organization of Senegal in the campaign to end FGM is Tostan, which has vast experience in successfully promoting the abandonment of the practice through its community education programmes based on human rights principles.

The involvement of NGOs and opinion leaders, particularly traditional and religious figures, has played an important role in raising awareness and stimulating public debate about FGM. In communities where there is a strong perception that the practice is required by Islam, for instance, the engagement of religious leaders in public discussion has proved to be essential in disassociating the practice from religious considerations and creating an enabling environment for change.

Partnership with religious leaders in Burkina Faso

BOX 11

In Burkina Faso, the involvement of Muslim religious leaders is deemed essential in persuading Muslim populations to abandon FGM. Hence it is highly significant that in 2011, 51 imams and one Catholic priest made public declarations supporting abandonment of the practice. The involvement of traditional leaders (local chiefs) in the campaign has also proved to be a powerful communication tool. Support from an especially influential chief led several villages to reject the practice.

With technical and financial support from the Joint Programme, the Network of Islamic Organizations for Population and Development produced a handbook in Arabic on 'Islam and FGM/C' which is used by Islamic preachers. In addition, a national conference on 'Islam and FGM/C: the Role of Religious Leaders', organized by the Network and hosted by a prominent Senegalese religious scholar attracted 94 participants – 72 men and 22 women.

Source: UNFPA-UNICEF Joint Programme on FGM/C: Accelerating Change, Annual Report 2011.

Support has been provided to local and national NGOs and community-based organizations to build and strengthen their capacities through various training programmes. Many NGOs and civil society groups have incorporated the human rights approach into their policies and programmes.

Religious networks have been supported to enable them to carry out dialogue sessions and peer-to-peer discussions, as well as to conduct study visits to neighboring countries and to engage in home visits. As a result, religious leaders have issued edicts, Fatwas or public statements in sermons; at awareness sessions, conferences and seminars; and during debates on television and in other media events.

7.8 Alternatives to FGM

In many communities FGM is performed as a rite of passage, marking an adolescent girl's transition to adulthood. It is a time for imparting traditional values, often accompanied by a celebration with dancing, food and drinks. Alternative rites of passage have been developed that preserve the positive sociocultural aspects of the ritual without requiring adolescent girls to undergo FGM. In Kenya (see box 12), as in communities in Gambia, Uganda and United Republic of Tanzania, alternative ceremonies have been well received. Such rites are accompanied by a process of participatory education that engages the whole community. Participating adolescent girls are given instruction on a wide range of topics designed to equip them for adulthood. They learn about the positive values of the local culture, life skills, communication skills, self-awareness, family relationships, sexuality, adolescent behavior issues, sexually transmitted diseases, HIV/AIDs, gender-based violence and human rights. They also learn how FGM violates

The rituals equip the adolescent girls to become mentors and role models for their peers.

Alternative rite of passage in Kenya

BOX 12

In Kenya, about 400 adolescent girls from Kuria, Mt. Elgon and Meru went through an alternative rite of passage in 2012 under UNFPA leadership. The community provided food for the girls for a week of seclusion where they learned life skills and were taught about positive interaction with boys, the importance of education for a successful future and the negative consequences of FGM and child marriage. In a final celebration with their parents and relatives, they celebrated mass at a local church, where they were blessed and awarded certificates of recognition for committing to stay uncut. Girls who have graduated from these alternative rites serve as fierce advocates, leading the march against the practice of FGM in their communities.

Source: Kenya Annual Report 2012, UNFPA-UNICEF Joint Programme on FGM/C

those rights. These rituals equip the adolescent girls to become mentors and role models for their peers and to participate in development processes in their homes, schools and communities.

7.9 Comprehensive and coordinated approach

A comprehensive and coordinated approach is crucial to accelerating the abandonment of FGM.

All five countries recognize that a comprehensive and coordinated approach is crucial to accelerating the abandonment of FGM. They understand that this harmful practice can be eliminated through a comprehensive national movement that involves all public and private stakeholders, including government institutions, community and religious leaders, educational institutions, the media, NGOs, civil society, girls and boys, and women and men.

The creation of a national secretariat or board is pivotal in coordinating and harmonizing the efforts of various stakeholders and in ensuring establishment of a national policy on FGM. The functions of a coordinating body generally include any or all of the following activities: designing and formulating policies and programmes; coordinating activities relating to FGM, including public awareness programmes that advise the government on matters relating to policies and implementation of laws; providing technical, logistical and other support to institutions, agencies, NGOs, religious groups, civil society and other entities engaged in programmes aimed at ending the practice; and facilitating resource mobilization for the activities aimed at FGM abandonment.

The coordination of FGM activities varies among the five countries, ranging from a single ministry (in Kenya) to several ministries (in Senegal). In Kenya, the Ministry of Gender, Children and Social Development is the mandated coordinating body for all government ministries, as well as NGOs and donors. A national study on FGM spearheaded by the Ministry led to creation of the FGM National Secretariat.

In Ethiopia, the National Committee on Traditional Harmful Practices was established to help overcome practices harmful to women's and children's health, including FGM. It provides information on the dangers posed by such practices and makes religious and traditional leaders aware of the need to abandon them. The committee's work emphasizes media campaigns and education of young people. The committee is a member of the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children.

In Egypt, the State created the National Council for Childhood and Motherhood to lead FGM abandonment activities. It works closely with various line ministries, UN agencies and other international and national

partners to mobilize the legal, medical and media communities to overcome medicalization of the practice. This includes integrating FGM into the in-service training package for medical practitioners provided by the Ministry of Health and Population and monitoring enforcement mechanisms. The council has set up a 24-hour child helpline toll-free number to answer questions and enable concerned citizens to report illegal operations.

In Burkina Faso, a turning point was creation of the CNLPE in 1990 and its permanent secretariat in 1997. The secretariat was also given responsibility for its budget. The CNLPE, which oversees all activities relating to FGM, uses multiple interventions involving religious leaders, the police force, medical professionals, teachers and youth and women's organizations in implementing the law banning FGM. This has ensured that messages on FGM are communicated to the wider public and included in development programmes.

In Senegal, the National Action Plan 2010-2015 on FGM follows a holistic approach, involving all relevant actors from the Government and civil society. A national technical committee has representatives from various ministries, such as health, education, youth and justice, as well as various NGOs and UN agencies. It meets regularly to endorse the decisions taken by the Direction de la Famille (Ministry of Family Affairs), which acts as the coordination unit in the framework of the action plan. The Government has established 11 committees at regional and county levels to follow up on local implementation of the action plan.

7.10 Financial support

While the international community has urged countries to allocate resources for implementation of policies, programmes and legislative frameworks, the funds have mainly come from donors and United Nations agencies. States' contributions have mainly been in the form of human resources to support implementation of activities and programme. A challenge facing the five countries and others is delayed disbursement of donor funds and poor predictability of funding, which have hampered long-term planning and timely implementation of activities. Despite the progress achieved in curtailing the practice of FGM, more funding is required to sustain momentum in the five countries and to further strengthen, develop and scale up existing programmes. In particular, resources are needed to build monitoring and evaluation capacities to determine which interventions are effective and which are not. The international community has underscored the need for more financial resources that will both help accelerate the abandonment of FGM globally and contribute to sustainable social change.

Urged countries to allocate resources for implementation of policies, programmes and legislative frameworks

CHAPTER EIGHT

Conclusions

RATIFICATION OF THE MAPUTO PROTOCOL AND REPORTING ISSUES

CRIMINALIZATION OF FGM

STRONGER ENFORCEMENT MECHANISMS

SYSTEM STRENGTHENING

CROSS-BORDER APPROACH

CAPACITY

POLITICAL WILL

LITIGATION AND SOCIAL ACCOUNTABILITY

THE WAY FORWARD



Despite numerous developments and progresses, FGM prevalence is still at an unacceptable level and the lack of accountability for violations experienced by girls and women is the rule rather than the exception in many countries. Globally, Member States have acknowledged that FGM is a human rights violation. However, this acknowledgement has not yet led to the adoption of necessary solutions that are coherent and sustainable, and which would lead to elimination of the practice. This concluding chapter summarizes the challenges and recommendations for future action on implementation of the international and regional human rights framework.

8.1 Ratification of the Maputo Protocol and reporting issues

Most African countries have signed and ratified international and regional human rights treaties. With the Maputo Protocol, the African Union created an instrument that pledges realization of the rights of women in Africa and commits the ratifying countries to concrete action regarding FGM. The protocol includes an obligation to “prohibit and condemn all forms of harmful practices which negatively affect the human rights of women and which are contrary to recognized international standards.” However, without the ratification by all African States, the protocol’s pledges cannot be fully realized. In addition, many African States do not respect their obligation, under article 26 of the protocol, to indicate in their periodic reports on fulfilment of the African Charter on Human and People’s Rights, the measures undertaken for full realization of women’s rights. The same issue exists with regard to the UN human rights treaty monitoring bodies: each State party is obligated to submit regular reports on implementation of the rights to the relevant treaty body, late reporting or failure to report presents serious challenges to the monitoring system. It is necessary that governments give priority to their reporting obligations.

8.2 Criminalization of FGM

The international and regional human rights framework requests States to ensure enactment and effective enforcement of national laws prohibiting FGM, to protect the human rights of women and girls from this form of violence and to end impunity. Many countries have passed criminal laws that include penalties for participation in the practice or provide protections and remedies for those who have undergone the procedure or are at risk of doing so. A study on implementation of the law prohibiting FGM in Senegal

also confirmed its limited impact.¹⁸⁶ This is due to the lack of consultation and participation of people during the process and the lack of dissemination and understanding of the law, including by civil servants. A report by A. Rahman and N. Toubia pointed out that “Stopping the practice by providing women with the information and choices to abandon FGM cannot be achieved by the simple act of drafting or interpreting a set of human rights principles or laws, even though such steps are necessary to enhance the process of change. To effect such profound social change, government action should take multiple forms and be part of a long-term process of guaranteeing human rights for all, particularly women and girls.”¹⁸⁷

8.3 Stronger enforcement mechanisms

The challenge faced by many governments is how to effectively implement and enforce legislation. A study on the implementation of Senegal’s law prohibiting FGM cited lack of consultation and participation of people during the drafting process and the lack of dissemination and understanding of the law, including by civil servants, had significantly limited the law effectiveness.

Overall, human rights protection systems are endemically weak, lacking adequate financial, technical and human resources to fulfil their mandates. Where there are examples of successful enforcement of legislation, strong national mechanisms are in place. Such mechanisms include an effective governmental coordinating body, independent human rights institutions, an impartial judiciary and an efficient law enforcement system.

National laws should be better monitored and court cases regarding FGM should be better reported. The responsibilities of all institutions need to be clearly established. Moreover, capacity-building initiatives to prevent and respond to incidents of FGM should reach all professionals working with and for children. Such initiative should include clear guidance and child-sensitive mechanisms and procedures.

Consensus to end FGM must be taken into account when discussing the effectiveness of legislation’s effectiveness. Public support, by necessity, must be won in order to facilitate legislation implementation. Women and girls must not be seen only as victims, but as agents of change and equal partners in ending discrimination and violence. Engagement with men and boys is necessary. Through dialogue and education men and boys are strong catalysts to change gender stereotypes, attitudes and beliefs. Additionally, international human rights frameworks and the provisions of human rights treaties and documents as well as national laws are little known or accessible by citizens. People need to be educated about international human rights standards and national legislation, policy and laws.

Services need to
be addressed
holistically

8.4 System strengthening

Capacity development of legal, health, judicial, gender and social development personnel is crucial. However, the institutionalization and strengthening of services need to be addressed holistically by developing a multisectoral sustained model of prevention, protection, punishment, provision of care and reparations. There is urgent needs for guidance to integrate FGM into sexual and reproductive health services for prevention of FGM and repair of injuries; mainstreaming it into legal and judicial services; and developing information management and referral systems for FGM cases. The lack of cultural sensitivity and gender responsiveness can be a barrier to realizing substantive protection for women and girls. Community, legal and health services need to be interlinked with bridges and a functional referral mechanism. Monitoring and evaluation systems, which would include data collection, and indicators, among others, do need to be in place to assess effectiveness and also the impact of measures and intervention adopted.

8.5 Cross-border approach

FGM permeates national borders which creates challenges when implementing the international human rights framework and national legislation. For example, Burkina Faso is surrounded by six countries (Benin, Côte d'Ivoire, Ghana, Mali, Niger and Togo), only one of which (Mali) has laws against FGM. Ghana's law even forbids FGM abroad. But when it comes to enforcement of these laws, Burkina Faso's record is far better than that of its neighbors. This means that Burkinabés who are intent on having their daughters cut can easily slip across the nearest border to have the practice performed.

Adding to this problem is inadequate coordination among national authorities in border areas and insufficient cooperation among the police and justice systems in these countries. Cooperation with neighboring countries is therefore crucial, as acknowledged by the treaty monitoring bodies. The Committee on the Rights of the Child called on Burkina Faso to "reinforce cooperation with neighboring counties in the region to combat FGM" and recommended that Sudan "continue and strengthen its efforts to end the practice of female genital mutilation and to seek cooperation with other countries in the region with a positive experience in combating this harmful practice." The African Union might need to facilitate a harmonization process. As recommended to Burkina Faso during the Universal Periodic Review, States need to "share best practices with other countries regarding female genital mutilation."



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8.6 Capacity

Unfortunately, insufficient resources are allocated for implementation of the international human rights framework aimed at abandonment of FGM. Governments have relied heavily on the assistance of the international community. However, national governments are responsible for reinforcing institutional frameworks and must be invested in the implementation and enforcement of laws on FGM.

8.7 Political will

Political will at national, regional and community levels play a crucial role. If political leaders are not engaged and if there is no political support to change the practice, it is almost impossible for the international human rights framework to have an impact. Political will is needed to continue to accelerate and sustain efforts to put an end to FGM. The Inter-African Committee has also argued that “political will is at the center of achieving zero tolerance to FGM.” Political leaders have publicly advocated for the abandonment of FGM but remain exception. However where political leaders have called attention to FGM a greater engagement of religious and traditional leaders follow and has facilitated the enactment and enforcement of the law.

8.8 Litigation and social accountability

National NGOs and public interest litigation groups need the skills to activate the application of national laws on FGM before national courts and other protection mechanisms. Beyond the prosecution of specific FGM perpetrators, public litigation can be a tool to compel governments to discharge their human rights obligations. For instance, these groups can litigate cases before courts to oblige States that have ratified the CRPD to provide rehabilitation services to women living with a disability resulting from FGM or to ensure the provision of treatment for FGM injuries.

In the area of social accountability, governments must ensure accessibility to public information. To better ensure monitoring of policy and programme implementation, civil society organizations need to request that national strategies are accompanied with plans that define the responsibility of different State agencies, benchmarks, and timelines and budget allocations. This information allows the monitoring of policy and programme implementation. Specific mechanisms for social participation and accountability need to be established in the context of these policies and programmes, and affirmative measures need to be taken to ensure participation by the groups of women and girls most severely affected by FGM.

8.9 The way forward

The relationship between legislation, human rights and positive social change manifested in efforts to support abandonment of FGM is complex. Gaining a better understanding of the mechanisms that address changes in social, political and legal norms is crucial to end FGM. Alternatively addressing the complex interactions between laws, policies and communities is necessary for positive, sustainable change. Much progress had been made in recent decades. The leadership of governments and their support of eliminating FGM have led to strengthened legal and policy frameworks at national and subnational levels; awareness and knowledge of FGM by national actors and community members has grown; increased commitment of community leaders and people to FGM abandonment and significant changes in public discourse.

However, the practice of FGM has not been eliminated. Human rights can help to accelerate the changes needed to end the practice, and to achieve gender equality, but they must not only exist on paper. Human rights need to become a reality in the daily lives of women and girls.

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15. World Health Organization, 'Eliminating female genital mutilation, An interagency statement', OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO, 2008.
16. Paulo Sérgio Pinheiro, 'World Report on Violence against Children', United Nations Secretary-General's Study on Violence against Children, 2006, p. 74.
17. Center for Reproductive Rights, 'Female Genital Mutilation, A Matter of Human Rights: An advocate's guide to action', New York, 2006, p. 5.
18. A. Rahman and N. Toubia, *Female Genital Mutilation, A Guide to Laws and Policies Worldwide*, Zed Books, 2000, pp. 38-39.
19. The UNFPA-UNICEF Joint Programme on FGM/C: Accelerating Change is currently the largest effort under way by the international community to encourage the abandonment of FGM. It has been implemented in 15 countries during phase I (2008-2013) and has just entered phase II (2014-2017).
20. Girls or women who fear being subjected to FGM and their parents who fear persecution for opposing a social norm are protected by the Convention relating to the Status of Refugees to seek asylum outside their country of nationality. A State that expels or returns a girl or woman to a country where she would be subjected to FGM would be in breach of its obligations under international human rights law. However, neither the Geneva Convention nor the Protocol relating to the Status of Refugees is included in the analysis of this paper.
21. http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/67/146&referer=http://www.un.org/depts/dhl/resguide/r67_en.shtml&Lang=E
22. <http://www.refworld.org/docid/478caaf72.html>
23. http://ec.europa.eu/justice/gender-equality/files/gender_based_violence/131125_fgm_communication_en.pdf
24. http://www.peacewomen.org/assets/file/Resources/NGO/hr_protocoltotheafricancharteronhumanandpeoplesrightsontherightsofwomeninafrica_2003.pdf
25. <http://www.legislationline.org/documents/id/7713>
26. http://www.un.org/womenwatch/daw/csw/csw52/statements_missions/Interagency_Statement_on_Eliminating_FGM.pdf
27. WHO, fact sheet N°241, Female genital mutilation, updated February 2014; see website: www.who.int/mediacentre/factsheets/fs241/en/.
28. The four WHO categories are: (1) Clitoridectomy: partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris); (2) excision: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are the 'lips' that surround the vagina); (3) infibulation: narrowing of the vaginal opening through the creation of a covering seal, which is formed by cutting and repositioning the inner or outer labia, with or without removal of the clitoris; and (4) other: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.
29. WHO, 'Sexual and Reproductive Health: Female genital mutilation and other harmful practices'; see website: www.who.int/reproductivehealth/topics/fgm/prevalence/en/index.html.

30. FGM has been documented among the Embera-Chami, an indigenous community in Colombia.
31. UNFPA, 'Demographic Perspectives on Female Genital Mutilation', New York 2014
32. See also: UNICEF, 'Changing a Harmful Social Convention: Female genital mutilation/cutting', Innocenti Research Centre, Florence, 2005; UNICEF, 'The Dynamics of Social Change: Towards the abandonment of FGM in five African countries', Innocenti Research Centre, Florence, October 2010; UNICEF, 'Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change', New York, July 2013, pp. 14-21.
33. For example, the FGM procedure that seals or narrows a vaginal opening (type 3) needs to be cut open later to allow for sexual intercourse and childbirth. Sometimes it is stitched again several times, including after childbirth, requiring the woman to go through repeated opening and closing procedures, further increasing both immediate and long-term risks.
34. WHO, fact sheet N°241, op. cit.: www.who.int/mediacentre/factsheets/fs241/en/
35. M. Sepúlveda, T. van Banning, G.D. Gudmundsdóttir, C. Chamoun and W.J.M. van Genugten, 'Human Rights Reference Handbook', University for Peace, 2004, p. 3.
36. Human Rights Day is celebrated annually across the world on 10 December, to honor the adoption of the UDHR.
37. Both the ICCPR and the ICESCR entered into force in 1976. The ICESCR has one Optional Protocol, of 2008, which enables State parties to accept additional procedures. It establishes a fully-fledged complaint procedure, including individual petitions, inquiries and inter-State complaints. Two Optional Protocols supplement the ICCPR and allow State parties to accept additional obligations. The first Optional Protocol, of 1966, provides for a right to individual petition; the second, of 1989, promotes abolition of the death penalty.
38. See also the OHCHR website: www.ohchr.org/EN/ProfessionalInterest/Pages/CoreInstruments.aspx.
39. Adopted: 21 December 1965; State parties: 176.
40. Adopted: 18 December 1979; State parties: 187.
41. Adopted: 10 December 1984; State parties: 153.
42. Adopted: 20 November 1989; State parties: 193.
43. Adopted: 18 December 1990; State parties: 46.
44. Adopted: 13 December 2006; State parties: 133.
45. Adopted: 20 December 2006; State parties: 39
46. OHCHR, 'The United Nations Human Rights Treaty System', fact sheet no. 30/rev.1, New York and Geneva, 2012, p. 19. For more information on treaties and treaty bodies, visit the OHCHR website: www.ohchr.org/.
47. For the Committee on Migrant Workers the individual complaint mechanisms have not yet entered into force. For more information on the procedure for complaints by individuals under the human rights treaties, see the OHCHR website: www.ohchr.org/EN/HRBodies/TBPetitions/Pages/IndividualCommunications.aspx#proceduregenerale.
48. The CESCR, CEDAW, CAT, CRC, CED, CRPD.
49. Several human rights treaties allow their State parties to complain to the relevant treaty body about alleged violations of the treaty by another State party. However, this procedure has never been used. For more information, see the OHCHR website: www.ohchr.org/EN/HRBodies/TBPetitions/Pages/HRTBPetitions.aspx.
50. CERD and CEDAW refer to their general comments as 'general recommendations'. For more information on the general comments of the human rights treaty bodies, and a compilation of all general comments of all human rights treaty bodies, see the OHCHR website: www.ohchr.org/EN/HRBodies/Pages/TBGeneralComments.aspx.
51. OHCHR, op. cit., p. 36.
52. The relatively new UN Human Rights Council is facing more and more criticism. Some scholars and experts on human rights argue that the Council is largely ineffective, which they blame primarily on the increased number of non-Western members with questionable human rights records (such as China, Cuba and Jordan).
53. For more information on the Human Rights Council, see the OHCHR website: www.ohchr.org/EN/HRBodies/HRC/Pages/AboutCouncil.aspx. For more information about the complaint procedure, see the OHCHR website: www.ohchr.org/EN/HRBodies/HRC/ComplaintProcedure/Pages/HRCComplaintProcedureIndex.aspx
54. For more information, see the OHCHR website: www.ohchr.org/EN/HRBodies/UPR/Pages/UPRmain.aspx.
55. For a list of country mandates, see the OHCHR website: www.ohchr.org/EN/HRBodies/SP/Pages/Countries.aspx.
56. There are currently 30 thematic mandates and 8 country mandates. For a list of thematic mandates, see the OHCHR website: www.ohchr.org/EN/HRBodies/SP/Pages/Themes.aspx.

57. http://africa-youth.org/youth_charter. Cf. Article 23.1.I: "Enact and enforce legislation that protect girls and young women from all forms of violence, genital mutilation, incest, rape, sexual abuse, sexual exploitation, trafficking, prostitution and pornography" and article 25 on "Elimination of harmful social and cultural practices".
58. A. Rahman and N. Toubia, *op. cit.*, p. 23.
59. *Ibid.* pp. 23-24.
60. General Assembly Resolution adopting the Declaration on the Elimination of Violence against Women (A/RES/48/104), 20 December 1993.
61. CEDAW, General Recommendation No. 19 on violence against women, Eleventh Session, 1992 (A/47/38).
62. Radhika Coomaraswamy, Preliminary report submitted by the Special Rapporteur on violence against women, its causes and consequences, to the Commission on Human Rights, Fifty-first Session, 1995 (E/CN.4/1995/42).
63. See UNFPA website: www.unfpa.org/gender/practices3_2.htm.
64. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (Mr. Paul Hunt) (E/CN.4/2004/49), 16 February 2004, point 25.
65. UN Committee against Torture, General Comment No. 2 (UN Doc CAT/C/GC/2), 2008, para. 18.
66. The previous UN Special Rapporteur on violence against women has clearly stated that FGM amounts to torture. In '15 Years of the Special Rapporteur on Violence Against Women, Its Causes and Consequences' (2009), it was noted that the Special Rapporteur "views cultural practices that involve pain and suffering and violation of physical integrity as amounting to torture under customary international law, attaching to such practices strict penal sanctions and maximum international scrutiny regardless of ratification of CEDAW or reservations made thereto". See also the 'Report of the Special Rapporteur on violence against women, its causes and consequences', Ms. Radhika Coomaraswamy, Commission on Human Rights, Fifty-eighth session, 31 January 2002 (E/CN.4/2002/83), para. 6.
67. Report by the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment (Mr. P. Kooijmans) (E/CN.4/1986/15), para. 38; and Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment (Mr. Manfred Nowak), 15 January 2008 (UN Doc. A/HRC/7/3), paras 50-54.
68. *Ibid.* para 51.
69. *Ibid.* para 53.
70. *Ibid.* para 38.
71. The Human Rights Committee has stated that FGM is in breach of article 7 of the ICCPR. See Committee on Civil and Political Rights, General Comment No. 28 on article 3 ICCPR (UN Doc. CCPR/C/21/Rev.1/Add.10), para 11.
72. Committee on the Rights of the Child, Concluding Observations, Togo, 21 Oct 1997, (CRC/C/15/Add.83), paras. 7 and 48.
73. A. Rahman and N. Toubia, *op. cit.*, p. 28.
74. All UN Member States except for Somalia, South Sudan and the United States.
75. For the right to culture, see for example art. 27 of the UDHR, art. 15 of the ICESCR, art. 29 of the Banjul Charter, art. 1 of the Declaration of the Principles of International Cultural Co-operation and art. 5 of the Declaration on Race and Racial Prejudice.
76. For the rights of minorities, see for example art. 27 of the ICCPR and art. 2 of the Declaration on the Rights of Persons Belonging to National or Ethnic, Religious and Linguistic Minorities.
77. For the right to religious freedom, see for example art. 18 of the UDHR, art. 18 of the ICCPR, art. 8 of the Banjul Charter, art. 1 of the Declaration on Religious Intolerance.
78. Center for Reproductive Rights, *op. cit.*, p. 16.
79. Due diligence should be understood as an obligation of States parties to the Conventions to prevent violence or violations of human rights, protect victims and witnesses from human rights violations, the obligation to investigate and punish those responsible, including private actors, and the obligation to provide access to redress for human rights violations. See Committee on the Elimination of Discrimination against Women Committee on the Rights of the Child, Joint general recommendation/general comment No. 31 of the Committee on the Elimination of Discrimination against Women and No. 18 of the Committee on the Rights of the Child on harmful practices, CEDAW/C/GC/31-CRC/C/GC/18, 4 November 2014, para. 10.
80. Art. 2(1) of the ICCPR states that "Each State Party to the present Covenant undertakes to respect and to ensure to all individuals within its territory and subject to its jurisdiction the rights recognized in the present Covenant [...]." Similarly, art. 2(1) of the ICESCR state that "Each State Party to the present Covenant undertakes to take steps, [...] to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures."

81. GA Resolution 48/104: Declaration on the Elimination of Violence against Women, article 4.
82. GA Resolution 61/143 on intensification of efforts to eliminate all forms of violence against women, para. 5. and GA Resolution 63/155 on intensification of efforts to eliminate all forms of violence against women, para. 9.
83. Beijing Declaration and Platform for Action, para. 124(a).
84. Reports of the Special Rapporteur on violence against women, its causes and consequences: (A/HRC/4/34), para. 30; and (A/HRC/7/6), para. 5.
85. Agreed conclusions on the elimination and prevention of all forms of violence against women and girls, 57th session, 4-15 March 2013 (E/2013/27, E/CN.6/2013/11), para. 14.
86. For instance the Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (Convention of Belem Do Para) and the Council of Europe Convention on preventing and combating violence against women and domestic violence (Istanbul Convention).
87. For example CEDAW General Recommendation no. 14 on Female Circumcision, CEDAW General Recommendation no. 19 on Violence against women, CEDAW General Recommendation no. 24 on Women and health, CRC General Comment No. 4 on Adolescent Health and Development in the Context of the Convention on the Rights of the Child, CRC General Comment No. 7 on Implementing child rights in early childhood, CRC General comment No. 13 on The Right of the Child to Freedom from all Forms of Violence.
88. Programme of Action of the International Conference on Population and Development, Cairo, 5-13 September 1994 (UN Doc. A/CONF.171/13/Rev.1), 1995, para. 4.22.
89. Beijing Declaration and Platform for Action, para. 124(i) and 283(d); ESCR General Comment No. 16 on the equal right of men and women to the enjoyment of all economic, social and cultural rights, para. 29.
90. GA Resolution 53/117 on traditional or customary practices affecting the health of women and girls (A/RES/53/117), 1 February 1999, para. 3(c).
91. www.dailynewseggypt.com/2014/03/12/egypt-doctor-faces-trial-fatal-female-genital-mutilation/.
92. GA Resolutions on traditional or customary practices affecting the health of women and girls: (52/99), para. 3(e); (54/133), para. 3(d); and (56/128), para. 3(d); GA Resolutions on the girl child: (58/156), para. 9; (60/141), para. 9; and (62/140), para. 13; GA Resolutions on intensification of efforts to eliminate all forms of violence against women: (61/143), para. 8(c); and (63/155), para. 16(b); and GA Resolution 67/146 on intensifying global efforts for the elimination of female genital mutilations, para. 4.
93. CESCR General Comment No. 16 on the equal right of men and women to the enjoyment of all economic, social and cultural rights, para. 29; CEDAW General Recommendation no. 24 on women and health, para. 15(d).
94. Reports of the Special Rapporteur on violence against women, its causes and consequences (E/CN.4/2002/83), para. 125; (E/CN.4/1996/53), paras. 102 and 142; A/HRC/7/6, para. 81; and (A/HRC/7/6/Add.5), paras 258 and 338; Report on torture and other cruel, inhuman or degrading treatment or punishment (E-CN/4-1986-15), para. 49; Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment (A/HRC/7/3), para. 76.
95. Report of the Secretary-General on traditional or customary practices affecting the health of women and girls (A/53/354, of 10 September 1998), para. 10; Report of the Secretary-General on traditional or customary practices affecting the health of women and girls (A/58/169, of 18 July 2003), para. 12; and Reports on ending female genital mutilation: (E/CN.6/2010/6), para. 1; and (E/CN.6/2012/8), para. 47.
96. Resolution on female genital mutilation (WHA61.16), para. 1(2).
97. GA Resolution 53/117 on traditional or customary practices affecting the health of women and girls, para. 3(c); GA Resolution 67/146 on intensifying global efforts for the elimination of female genital mutilations, para. 12; Commission on the Status of Women, Ending female genital mutilation (E/CN.6/2010/L.8, para. 15); Report on ending female genital mutilation (E/CN.6/2012/8), para. 48.
98. CRC, 49th Sess., Concluding observations, Djibouti (CRC/C/DJI/CO/2), 7 Oct 2008; CEDAW, 45th Sess., Summary record of the 918th meeting, Combined sixth and seventh periodic reports of Egypt (CEDAW/C/SR.918), 1 Apr 2010; CRC, 43rd Sess., Concluding observations, Ethiopia (CRC/C/ETH/CO/3), 1 Nov 2006; CEDAW, 39th Sess., Summary record of the 795th meeting, Consideration of reports submitted by States parties under article 18 of the Convention, Guinea (CEDAW/C/SR.795 (A)), 25 Jul 2007; CRC, 44th Sess., Concluding observations, Kenya (CRC/C/KEN/CO/2), 19 Jun 2007; CAT, 44th Sess., List of issues prior to the submission of the third report of Senegal.

99. CCPR General Comment No. 28 on equality of rights between men and women (article 3), para. 3; CESCR General Comment No. 14 on the right to the highest attainable standard of health, para. 22; CRC General Comment No. 13 on the right of the child to freedom from all forms of violence (CRC/C/GC/13), para. 72(g); GA Resolution 56/128 on traditional or customary practices affecting the health of women and girls, para. 3(h); GA Resolution 61/143 on intensification of efforts to eliminate all forms of violence against women, para. 8(f); Report and Programme of Action of the International Conference on Population and Development, Cairo, 5-13 September 1994 (A/CONF.171/13/Rev.1), para. 5.5; Report of the World Summit for Social Development, Copenhagen, 6-12 March 1995, para. 79(b); Commission on the Status of Women, Resolution 51/1 on women, the girl child and HIV and AIDS, para. 13.
100. Commission on the Status of Women, 'Ending female genital mutilation' (E/CN.6/2010/L.8), para. 15.
101. Report of the Special Rapporteur on violence against women, its causes and consequences (E/CN.4/2002/83), para. 126; GA Resolution 67/146 on intensifying global efforts for the elimination of female genital mutilations, para. 12.
102. CEDAW General Recommendation No. 14 on female circumcision.
103. GA Resolution 67/146 on intensifying global efforts for the elimination of female genital mutilations, para. 7; Report on ending female genital mutilation (E/CN.6/2010/6), para. 40.
104. Reports of the Special Rapporteur on violence against women, its causes and consequences: (A/HRC/4/34), para. 29; (E/CN.4/1996/53), para. 102; and (E/CN.4/2002/83), para. 126; GA Resolution 48/104, Declaration on the Elimination of Violence against Women, article 4.
105. GA Resolution 67/146 on intensifying global efforts for the elimination of female genital mutilations, para. 14; Commission on the Status of Women: Ending female genital mutilation (E/CN.6/2010/L.8), paras 3, 27 and 22; UN Secretary-General's Report on ending female genital mutilation (E/CN.6/2010/6), para. 40.
106. UN Secretary-General's Report on ending female genital mutilation (E/CN.6/2012/8), para. 47.
107. GA Resolution 62/140 on the girl child, para. 29.
108. GA Resolutions on traditional or customary practices affecting the health of women and girls: (54/133), para. 3(c); and (56/128), para. 3(c); Commission on the Status of Women, Resolution 51/3 on forced marriage of the girl child, para. 3(e); Report of the Special Rapporteur on violence against women, its causes and consequences (E/CN.4/2002/83), para. 130; Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment (A/HRC/7/3), para 76; Reports of the Secretary-General on traditional or customary practices affecting the health of women and girls (A/53/354), 10 September 1998, paras 15 and 34; and (A/58/169), 18 July 2003, para. 49.
109. CEDAW General Recommendation no. 14 on female circumcision.
110. Report and Programme of Action of the International Conference on Population and Development, Cairo, 5-13 September 1994 (A/CONF.171/13/Rev.1), para. 12.13.
111. GA Resolution 67/146 on intensifying global efforts for the elimination of female genital mutilations, para. 13.
112. Report of the Secretary-General on ending female genital mutilation (E/CN.6/2012/8), para. 53.
113. CEDAW General Recommendation no. 14 on female circumcision; and GA Resolution 67/146 on intensifying global efforts for the elimination of female genital mutilations, para. 9.
114. See art. 5(a) of the Maputo Protocol: "States Parties shall take all necessary legislative and other measures to eliminate such practices, including: a) creation of public awareness in all sectors of society regarding harmful practices through information, formal and informal education and outreach programmes."

115. GA Resolutions on traditional or customary practices affecting the health of women and girls: (52/99), para. 2(d); (53/117), para. 3(d); and (54/133), para. 3(g); Report and Programme of Action of the International Conference on Population and Development, Cairo, 5-13 September (1994 A/CONF.171/13/Rev.1), para. 13.14(b); Beijing Declaration and Platform for Action and the Report of the Fourth World Conference on Women, paras. 107(a), 124(k) and 276(b); Commission on the Status of Women, Ending female genital mutilation (E/CN.6/2010/L.8), paras. 3, 7, 10 and 23; Reports of the Special Rapporteur on violence against women, its causes and consequences (E/CN.4/2002/83), para. 114 and (E/CN.4/1996/53), paras. 112 and 114; Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (A/66/254), para. 57; Reports of the Secretary-General on traditional or customary practices affecting the health of women and girls (A/53/354, 10 September 1998), paras. 2, 7, 17, 40 and 54; (A/56/316, 22 August 2001), paras. 9 and 40; and (A/58/169, 18 July 2003), paras. 24 and 49; Reports of the Secretary-General on ending female genital mutilation (E/CN.6/2010/6), para. 21 and (E/CN.6/2012/8), para. 50; World Health Assembly Resolution on female genital mutilation (WHA61.16), para. 1(1).
116. ICCPR, 83rd Sess., Concluding observations of the Human Rights Committee, Kenya (CCPR/CO/83/KEN), 29 Apr 2005; CEDAW, 39th Sess., Concluding comments, Kenya (CEDAW/C/KEN/CO/6), 10 Aug 2007; CRC, 44th Sess., Concluding observations, Kenya (CRC/C/KEN/CO/2), 19 Jun 2007; ICCPR, 61st Sess., Concluding observations, Senegal (CCPR/C/79/Add.82), 19 Nov 1997; CAT, 41st Sess., Consideration of reports submitted by States Parties under article 19 of the CAT, Consideration of reports submitted by States Parties under article 19 of the Convention, Concluding observations, Kenya (CAT/C/KEN/CO/1), 19 Jan 2009; CRC, 43rd Sess., Concluding observations, Senegal (CRC/C/SEN/CO/2), 20 Oct 2006; Universal Periodic Review Senegal, Review in the Working Group, 6 Feb 2009, Adoption in the Plenary, 11 Jun 2009.
117. CRC General Comment No. 4 on adolescent health and development in the context of the Convention on the Rights of the Child (CRC/GC/2003/4), para. 20; CRC General Comment No. 13 on the right of the child to freedom from all forms of violence (CRC/GC/13), para. 44.
118. CEDAW General Recommendation no. 14 on female circumcision, para. 24(f); GA Resolution 63/155 on intensification of efforts to eliminate all forms of violence against women, para. 16(i).
119. GA Resolutions on traditional or customary practices affecting the health of women and girls, (54/133) para. 3(i) and (56/128), para. 3(k).
120. CRC General Comment No. 4 on adolescent health and development in the context of the Convention on the Rights of the Child (CRC/GC/2003/4), para. 20.
121. GA Resolution 67/146 on intensifying global efforts for the elimination of female genital mutilations, para. 2.
122. Ibid. para. 3.
123. GA Resolutions on traditional or customary practices affecting the health of women and girls (54/133) para. 3(e); and (56/128), para. 3(f).
124. CEDAW General Recommendation no. 24 on women and health, para. 15.
125. GA Resolution 56/128 on traditional or customary practices affecting the health of women and girls, para. 3(g).
126. Commission on the Status of Women, Ending female genital mutilation (E/CN.6/2010/L.8), para. 18.
127. Report of the Secretary-General on ending female genital mutilation (E/CN.6/2010/6), para. 39.
128. CESCR General Comment No. 16 on the equal right of men and women to the enjoyment of all economic, social and cultural rights, para. 29; GA Resolution 54/133 on traditional or customary practices affecting the health of women and girls, para. 3(h); Beijing Declaration and Platform for Action and the Report of the Fourth World Conference on Women, para. 106(a); Review of Reports, Studies and other Documentation for the Preparatory Committee and the World Conference (A/CONF.189/PC.3/5), para. 207; Commission on Human Rights, Reports on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 2004, para. 85, and (A/60/348), para. 12; and Report of the Secretary-General on traditional or customary practices affecting the health of women and girls (A/53/354, 10 Sep 1998), paras 34 and 54.
129. GA Resolution 52/99 on traditional or customary practices affecting the health of women and girls, para. 1(f).
130. CEDAW General Recommendation no. 14 on female circumcision; GA Resolution 52/99 on traditional or customary practices affecting the health of women and girls, para. 3(f); Reports of the Secretary-General on traditional or customary practices affecting the health of women and girls (A/53/354, 10 September 1998), para. 25, and (A/56/316, 22 August 2001), para. 12; Report of the Secretary-General on ending female genital mutilation (E/CN.6/2012/8), para. 49; World Health Assembly Resolution on female genital mutilation (WHA61.16), para. 1(4).
131. Report of the Special Rapporteur on violence against women, its causes and consequences (E/CN.4/2002/83), para. 132.
132. Report of the Special Rapporteur on violence against women, its causes and consequences, *ibid.* para. 113.

133. GA Resolution 67/146 on Intensifying global efforts for the elimination of female genital mutilations, para. 5; Commission on the Status of Women: Ending female genital mutilation E/CN.6/2010/L.8, para. 14; See also Art. 5(c) and 5(d) of the Maputo Protocol.
134. CESCR General Comment No. 14 on the right to the highest attainable standard of health, para. 35.
135. GA Resolutions on the girl child: (58/156) para. 9, (60/141), para. 9 and (62/140), para. 13; Beijing Declaration and Platform for Action and the Report of the Fourth World Conference on Women, para. 93; Report of the Secretary-General on ending female genital mutilation (E/CN.6/2012/8), para. 52; Resolution on female genital mutilation (WHA61.16), para. 1(5).
136. Report and Programme of Action of the International Conference on Population and Development, Cairo, 5-13 September 1994, A/CONF.171/13/Rev.1, para. 7.40.
137. Report of the Secretary-General on ending female genital mutilation (E/CN.6/2010/6), para. 41.
138. Report of the Special Rapporteur on violence against women, its causes and consequences (A/HRC/7/6), para. 98.
139. GA Resolution 67/146 on intensifying global efforts for the elimination of female genital mutilations, para. 2.
140. *Ibid.* para. 10.
141. Commission on the Status of Women, Ending female genital mutilation (E/CN.6/2010/L.8), paras. 8 and 18; Report of the Special Rapporteur on violence against women, its causes and consequences (A/HRC/4/34), para. 31; Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (A/66/254), para. 57; Reports of the Secretary-General on ending female genital mutilation (E/CN.6/2010/6), para 38, and (E/CN.6/2012/8), paras 47, 50 and 54.
142. GA Resolutions on traditional or customary practices affecting the health of women and girls, (54/133) para. 3(j) and (56/128), para. 3(i); GA Resolution 67/146 on intensifying global efforts for the elimination of female genital mutilations, para. 3; Report of the Secretary-General on traditional or customary practices affecting the health of women and girls (A/56/316), 22 August 2001, para. 40.
143. GA Resolution 54/133 on traditional or customary practices affecting the health of women and girls, para. 3(l).
144. Report of the Secretary-General on ending female genital mutilation (E/CN.6/2010/6), para. 41.
145. GA Resolution 56/128 on traditional or customary practices affecting the health of women and girls, para. 3(m); Report of the Secretary-General on traditional or customary practices affecting the health of women and girls (A/53/354, 10 Sep 1998), para. 14; Report of the Secretary-General on ending female genital mutilation (E/CN.6/2010/6), para. 42.
146. CRC, 43rd Sess., Concluding observations, Ethiopia (CRC/C/ETH/CO/3), 1 Nov 2006; and Report of the Secretary-General on traditional or customary practices affecting the health of women and girls (A/53/354), 10 Sep 1998, paras 14 and 55.
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Delivering a world where
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every childbirth is safe and
every young person's
potential is fulfilled.



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